DOCUMENT RESUME

ED 167 849 CG 013 196

TITLE	Adolescent Health Services, and Pregnancy Prevention Care Act of 1978. Hearing Before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-Fifth Congress, Second Session, June 28, 1978.
INSTITUTION	Congress of the U. S., Washington, D. C. House Committee on Interstate and Foreign Commerce.
PUB DATE	28 Jun 78
NOTE	255p.; Not available in hard copy due to marginal legibility of original document
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Adolescents; *Community Health Services; Community Programs; Contraception; *Family Life Education; *Health Programs; Individual Needs; Pregnancy; *Pregnant Students; Public Health Legislation; *Youth Problems

ABSTRACT

The materials contained in these hearings represent the statements of witnesses before one of the subcommittees of the Committee on Interstate and Foreign Commerce of the House of Representatives. Witnesses include members of Congress, a pediatrician from John Hopkins School of Medicine, HEW Secretary Califano, R. Sargent Shriver, and various associations interested in child welfare and population growth. The statements address the following areas of concern: (1) prevention of unwanted pregnancies; (2) assistance to pregnant adolescents; (3) development of community based health services for pregnant youth; and (4) training of personnel to provide appropriate services. (HLM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED167849

ADOLESCENT HEALTH SERVICES, AND PREGNANCY PREVENTION CARE ACT OF 1978

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

H.R. 12146

A BILL TO ESTABLISH A PROGRAM FOR DEVELOPING NETWORKS OF COMMUNITY-BASED SERVICES TO PREVENT INITIAL AND REPEAT PREGNANCIES AMONG ADOLESCENTS, TO PROVIDE CARE TO PREGNANT ADOLESCENTS, AND TO HELP ADOLESCENTS BECOME PRODUCTIVE INDEPENDENT CONTRIBUTORS TO FAMILY AND COMMUNITY LIFE

JUNE 28, 1978

Serial No. 95–113

Printed for the use of the
Committee on Interstate and Foreign Commerce

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

U.S. GOVERNMENT PRINTING OFFICE
32-704 O WASHINGTON : 1978

CG 013196

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN E. MOSS, California
JOHN D. DINGELL, Michigan
PAUL G. ROGERS, Florida
LIONEL VAN DEERLIN, California
FRED B. ROONEY, Pennsylvania
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
CHARLES J. CARNEY, Ohio
RALPH H. METCALFE, Illinois
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
ROBERT (BOB) KRUEGER, Texas
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
MARTY RUSSO, Illinois
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BOB GAMMAGE, Texas
ALBERT GORE, JR., Tennessee
BARBARA A. MIKULSKI, Maryland

SAMUEL L. DEVINE, Ohio
JAMES T. BROYHILL, North Carolina
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JOE SKUBITZ, Kansas
JAMES M. COLLINS, Texas
LOUIS FREY, JR., Florida
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
W. HENSON MOORE, Louisiana
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania

W. E. WILLIAMSON, *Chief Clerk and Staff Director*
KENNETH J. PAINTER, *First Assistant Clerk*
ELEANOR A. DINKINS, *Assistant Clerk*
WILLIAM L. BURNS, *Printing Editor*

PROFESSIONAL STAFF

ELIZABETH HARRISON
JEFFREY H. SCHWARTZ
BRIAN R. MOIR
KAREN F. NELSON
ROSS D. AIN
CHRISTOPHER E. DUNNE
WILLIAM M. KITZMILLER
MARK J. RAABE
THOMAS M. RYAN

ROBERT HENLEY LAMB, *Associate Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

PAUL G. ROGERS, Florida, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
JAMES J. FLORIO, New Jersey
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
RICHARD L. OTTINGER, New York
DOUG WALGREN, Pennsylvania
HARLEY O. STAGGERS, West Virginia
(Ex Officio)

TIM LEE CARTER, Kentucky
JAMES T. BROYHILL, North Carolia
EDWARD R. MADIGAN, Illinois
JOE SKUBITZ, Kansas
SAMUEL L. DEVINE, Ohio (Ex Officio)

STEPHEN E. LAWTON, *Counsel*
ROBERT W. MAHER, *Director of Research and Planning*
JO ANNE GLISSON, *Senior Staff Associate*
DONALD W. DALRYMPLE, *Assistant Counsel*
STEPHEN J. CONNOLLY, *Senior Staff Associate*
BURKE ZIMMERMAN, *Research Associate*
ROBERT M. CRANE, *Senior Staff Associate*
WILLIAM V. CORR, *Assistant Counsel*
FRANCES DE PEYSTER, *Minority Staff Associate*

CONTENTS

	Page
Text of—	
H.R. 12146	3
Report of Health, Education, and Welfare Department on H.R. 12146	16
Statement of—	
Beilenson, Hon. Anthony C., a Representative in Congress from the State of California	18
Califano, Hon. Joseph A., Jr., Secretary, Department of Health, Education, and Welfare	25
Cohen, Hon. William S., a Representative in Congress from the State of Maine	23
Hardy, Janet, M.D., professor of Pediatrics, Johns Hopkins School of Medicine, director of Johns Hopkins Center for School Age Mothers and Their Infants	52
Shriver, R. Sargent, Washington, D.C	52
Shriver, Mrs. R. Sargent, Washington, D.C	52
Additional material submitted for the record by—	
Health and the Environment Subcommittee, Interstate and Foreign Commerce Committee:	
Letter dated July 17, 1978, from Chairman Rogers to Secretary Califano re questions by subcommittee members	34
Supplementary statement of Hon. James H. Scheuer	88
Table 1—Birth rates of women under age 20, according to age and race of mother: United States, 1966–76	98
Table 2—15–19-year-old women, 1971 and 1976	99
Table 5—Summary: Adolescent pregnancies and births, 1976, compared to those expected if sexually active teens had maintained 1971 birth and pregnancy rates	100
Health, Education, and Welfare Department:	
Letter, dated August 17, 1978, from Secretary Califano to Chairman Rogers, re answers to questions of the subcommittee	35
Shriver, R. Sargent, attachments to prepared statement:	
Letter, dated June 19, 1978, from Dr. Jekel to Senator Williams, re concerns of H.R. 12146	74
Letter, dated June 27, 1978, from Mayor Schaefer to Chairman Rogers, re launching of a comprehensive approach to teenage pregnancy prevention	77
Letter, dated June 28, 1978, from Mr. Kettleman to Chairman Rogers, re strong support of H.R. 12146	79
Statements submitted for the record by—	
American Academy of Pediatrics	202
American Citizens Concerned for Life	120
American Social Health Association	141
Center for Population and Family Health	169
Child Welfare League of America, Inc	160
Governor's (Maryland) Commission on Children and Youth	104
National Alliance Concerned with School Age Parents	106
National Foundation—March of Dimes	211
United States Catholic Conference	192
Zero Population Growth	147
Letters submitted for the record by—	
Baltimore, city of, Quentin R. Lawson, human resources coordinator	233
National Conference of Catholic Charities, Mathew H. Ahmann, associate director for governmental relations	244
School of Medicine, Johns Hopkins University, Janet B. Hardy, M.D., professor of pediatrics	222

ADOLESCENT HEALTH SERVICES, AND PREGNANCY PREVENTION CARE ACT OF 1978

WEDNESDAY, JUNE 28, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met pursuant to notice, at 2:45 p.m., in room 2218, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

Adolescent pregnancy has recently emerged as a major issue of public concern. Nearly 1 million adolescents—1 of every 10 adolescent females—become pregnant each year. Four hundred thousand of these young women are 17 years of age or younger; 30,000 are 14 and under.

Approximately two-thirds of teenage pregnancies occur in adolescents who are unmarried at the time of conception. Seventy percent of all premarital adolescent pregnancies are unintended. In excess of 300,000 abortions are reported each year in this population group.

The ramifications of teenage pregnancy are multiple. The effects on the health, education, social and economic welfare of those directly involved—as well as the implications for society as a whole—cannot be overstated. There are particular health hazards for young mothers and their infants, in addition to the potential loss of productivity to society when teenage mothers are unable to complete their education.

The proposal under consideration today is the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978. At the request of the administration, Congressman Brademas and I introduced this bill on April 17, 1978. The bill has been referred jointly to this subcommittee and to the Committee on Education and Labor. Accordingly, the primary focus of our hearing will be the health implications of this initiative.

The many health issues currently before the subcommittee have created severe scheduling constraints for us. However, because of the need to begin consideration of this important proposal, we have scheduled an abbreviated hearing this afternoon. While we have had to limit the number of witnesses appearing before the subcommittee today, we have solicited a wide range of comment from interested organizations and individuals. Their responses will be

made a part of this hearing record. [See p. 104.] Of course, any additional public comment will be welcome as well.

Dr. Carter, do you have any comment?

Mr. CARTER. I have a statement, Mr. Chairman.

Mr. Chairman, I am pleased to be here as a member of this subcommittee considering the problem of teenage pregnancy. As you know, the pregnancy rate of young women aged 15 to 19 has reached an alarming figure of at least 1.1 million pregnancies in 1976. And, of those young women who carry a pregnancy to term, 90 percent elect to keep their infants.

These are numbers, however, and they do not reflect the multitude of economic, social, psychological and medical problems which accompany teenage pregnancy. The stress of pregnancy places additional strain on the still developing body and mind. In addition, the young mothers often fail to complete either high school education or vocational training, and this seriously affects their ability to gain employment.

Therefore, I support the objectives of this proposed legislation. It represents an important step in providing support to these young people and helping them to meet the responsibilities of adulthood.

I wish to commend our distinguished panel for their efforts in this area, and I look forward to hearing from them.

Mr. ROGERS. Thank you very much. I think you had comments, Mr. Scheuer.

Mr. SCHEUER. Very briefly, Mr. Chairman. We will have plenty of time to get into the details of the Administration's proposal.

I do want to congratulate the President and Secretary Califano for what was an epoch-making event—the mere fact that the administration is courageously facing up to what is an epidemic problem in our society. They described the problem eloquently, and now they are facing it. We will have some nitpicking to do about the details, the nuts and bolts of their recommendations, but I do want to state as strongly as I can my feeling of gratitude and appreciation to the Secretary and to the President for having placed before the American people what is surely one of the most sensitive, and important problems facing our society today. I think it was a great public service.

Mr. ROGERS. Thank you very much.

Without objection, the text of H.R. 12146 and any agency reports thereon, will be printed at this point in the record.

[Testimony resumes on p. 18.]

[The text of H.R. 12146 and agency report thereon follow:]

95TH CONGRESS
2D SESSION

H. R. 12146

IN THE HOUSE OF REPRESENTATIVES

APRIL 17, 1978

Mr. BRADEMAS (for himself and Mr. ROGERS) (by request) introduced the following bill; which was referred jointly to the Committees on Education and Labor and Interstate and Foreign Commerce

A BILL

To establish a program for developing networks of community-based services to prevent initial and repeat pregnancies among adolescents, to provide care to pregnant adolescents, and to help adolescents become productive independent contributors to family and community life.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978".

FINDINGS AN PURPOSES

SEC. 2. (a) The Congress finds that—

(1) adolescents are at a high risk of unwanted pregnancy;

(2) in 1975, almost one million adolescents became pregnant and nearly six hundred thousand carried their babies to term;

(3) pregnancy and childbirth among adolescents, particularly young adolescents, often results in severe adverse health, social, and economic consequences, including a higher percentage of pregnancy and childbirth complications; a higher incidence of low birth weight babies; a higher frequency of developmental disabilities; higher infant mortality and morbidity; a decreased likelihood of completing schooling; a greater likelihood that adolescent marriage will end in divorce; and higher risks of unemployment and welfare dependency;

(4) an adolescent who becomes pregnant once is likely to experience rapid repeat pregnancies and childbearing, with increased risks;

(5) the problems of adolescent pregnancy and parenthood are multiple and complex and are best approached through a variety of integrated and essential services;

(6) such services, including a wide array of educational and supportive services, often are not available to the adolescents who need them, or are available but

fragmented and thus of limited effectiveness in preventing pregnancies and future welfare dependency; and

(7) Federal policy therefore should encourage the development of appropriate health, educational, and social services where they are now lacking or inadequate, and the better coordination of existing services where they are available, in order to prevent unwanted early and repeat pregnancies and to help adolescents become productive independent contributors to family and community life.

(b) It is, therefore, the purpose of this Act—

(1) to establish better linkages among existing programs in order to expand and improve the availability of, and access to, needed comprehensive community services which assist in preventing unwanted initial and repeat pregnancies among adolescents, enable pregnant adolescents to obtain proper care, and assist pregnant adolescents and adolescent parents to become productive independent contributors to family and community life;

(2) to expand the availability of community services that are essential to that objective; and

(3) to promote innovative, comprehensive, and integrated approaches to the delivery of such services.

TITLE I—GRANT PROGRAM

AUTHORITY TO MAKE GRANTS

SEC. 101. The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as "the Secretary") may make grants to public and nonprofit private agencies and organizations to support projects which he determines will help communities coordinate, and establish linkages among, services that will further the purposes of this Act and, where appropriate, will provide, supplement, or improve the quality of such services.

USES OF GRANTS

SEC. 102. (a) Funds provided under this Act may be used by grantees to—

(1) link services to—

(A) prevent unwanted initial and repeat pregnancies among adolescents; and

(B) assist adolescents who are pregnant or who have already had their babies to obtain proper care, prevent unwanted repeat pregnancies, and become productive and independent contributors to family and community life;

(2) identify and provide access to other services for adolescents to help prevent unwanted pregnancy and assist adolescents in becoming productive and independent contributors to family and community life;

(3) supplement services and care not adequate in the community which are essential to the prevention of adolescent pregnancy and to assist adolescents in becoming productive and independent contributors to family and community life;

(4) plan for the administration and coordination of pregnancy prevention and pregnancy-related services for adolescents which will further the objectives of the Act;

(5) provide technical assistance to enable other communities to develop successful pregnancy prevention and pregnancy-related programs for adolescents; and

(6) provide training (but not including institutional training or training and assistance provided by consultants) to providers of services, including skills in multidisciplinary approaches to pregnancy prevention and pregnancy-related services for adolescents and in the provision of such services.

(b) For purposes of this Act, projects which link services means projects which enable the provision of a comprehensive set of services in a single setting or establish a well-coordinated network of services in a community, including outreach to adolescents, the making available of services in a convenient manner and in easily accessible locations, and followup to assure that the adolescent is receiving appropriate assistance. The services which may be

included in such projects include, but are not limited to family planning services, education at the community level concerning sexuality and the responsibilities of parenthood, health, mental health, nutrition, education, vocational, and employment counseling, prenatal and postpartum health care, residential care for pregnant adolescents, and services to enable pregnant adolescents to remain in school or to continue their education.

(c) Grantees may not establish income eligibility requirements for services paid for with funds under this Act, but grantees shall insure that priority is given to the objective of making such services available to adolescents at risk of initial or repeat pregnancies who are not able to obtain needed assistance through other means.

(d) Grantees may charge fees for services paid for with funds under this Act, but only pursuant to a fee schedule, approved by the Secretary as a part of the application described in section 104, which bases fees charged by the grantee on the income of the service recipients or parents and takes account of the difficulty adolescents face in obtaining resources to pay for services.

(e) Except as provided in this subsection, in no case may a grantee under this Act use in excess of 50 per centum of its grant under this Act in any year to cover any part of

the cost of services. The Secretary may grant a waiver of the limitation specified in the preceding sentence in accordance with criteria to be specified in regulations.

PRIORITIES, AMOUNTS, AND DURATION OF GRANTS

SEC. 103. (a) In approving applications for grants under this Act, the Secretary shall give priority to applicants who—

(1) serve an area where there is a high incidence of adolescent pregnancy;

(2) serve an area where the incidence of low income families is high and where the availability of pregnancy related services is low;

(3) show evidence of having the ability to bring together a wide range of needed services in comprehensive single-site projects, or to establish a well integrated network of outreach to, and services for, adolescents at risk of initial or repeat pregnancies;

(4) will utilize, as a base, existing programs and facilities, such as neighborhood and primary health care centers, children and youth centers, maternal and infant health centers, school educational programs, mental health programs, nutrition programs, recreation programs, and other ongoing pregnancy prevention and pregnancy-related services;

(5) make use, to the maximum extent feasible, of other Federal, State, and local funds, programs, contributions, and other third party reimbursements;

(6) can demonstrate a community commitment to the program by making available to the project non-Federal funds, personnel, and facilities; and

(7) have involved the community to be served, including public and private agencies, adolescents and families, in the planning and implementation of the project.

(b) The amount of a grant under this Act shall be determined by the Secretary, based on factors such as the incidence of adolescent pregnancy in the geographic area to be served, and the adequacy of pregnancy prevention and pregnancy-related services in the area to be served.

(c) (1) A grantee may not receive funds under this Act for a period in excess of five years.

(2) The grant may cover not to exceed 70 per centum of the costs of a project assisted under this Act for the first and second years of the project. Subject to paragraph (3), in each year succeeding the second year of the project the amount of the Federal grant under this Act shall decrease by no less than 10 per centum of the amount of the Federal grant under this Act in the preceding year.

(3) The Secretary may waive the limitation specified in

the preceding paragraph in any year in accordance with criteria to be specified in regulations.

REQUIREMENTS FOR GRANT APPROVAL

SEC. 104. (a) An application for a grant under this Act shall be in such form and contain such information as the Secretary may require, but must include—

(1) an identification of the incidence of adolescent pregnancy and related problems;

(2) a description of the economic conditions and income levels in the geographic area to be served;

(3) a description of existing pregnancy prevention and pregnancy-related services, including where, how, by whom and to whom they are provided, and the extent to which they are coordinated in the geographic area to be served;

(4) a description of the major unmet needs for services for adolescents at risk of initial or repeat pregnancies, the number of adolescents currently served in the area, and the number of adolescents not being served in the area;

(5) a description of certain core services to be included in the project or provided by the grantee, to whom they will be provided, how they will be linked, and their source of funding, to include some, but not necessarily all, of the following;

(A) family planning services;

(B) health and mental counseling;

(C) vocational counseling;

(D) educational services, which supplement regular school programs, to help prevent adolescent pregnancy and to assist pregnant adolescents and adolescent parents to remain in school or to continue their education;

(E) primary and preventive health services including pre- and post-natal care; and

(F) nutritional services, and nutritional information and counseling;

(6) a description of how adolescents needing services other than those provided directly by the grantee will be identified and how access and appropriate referral to those services (such as medicaid; public assistance; employment services; infant, day and drop-in care services for adolescent parents; and other city, county and State programs related to adolescent pregnancy) will be provided;

(7) a description of any fee schedule to be used for any services provided directly by the grantee and the method by which it was derived;

(8) a description of the grantee's capacity to

sustain funding as Federal funds are phased down and out;

(9) a description of all the services and activities to be linked, the results expected from the provision of such services and activities, and a description of the procedures to be used for evaluating those results;

(10) a summary of the views of public agencies, providers of services, and the general public in the geographic area to be served, of the proposed use of the grant provided under this Act and a description of procedures used to obtain those views, and, in the case of applicants who propose to coordinate services administered by a State, the written comments of the appropriate State officials responsible for such services; and

(11) a description of how the services and activities funded with a grant under this Act would be coordinated with existing related programs in the geographic area to be served by the grantee.

(b) Each grantee which participates in the program established by this title shall make such reports concerning its use of Federal funds as the Secretary may require. Reports shall include the impact the project has had on reducing the rate of first and repeat pregnancies among

32-704 O - 78 - 3

adolescents, and the effect or factors usually associated with welfare dependency.

AUTHORIZATION OF APPROPRIATIONS

SEC. 105. For the purpose of carrying out this title, there are authorized to be appropriated $60 million for the fiscal year 1979, and such sums as may be necessary for the fiscal year 1980 and the fiscal year 1981.

TITLE II—IMPROVING COORDINATION OF FEDERAL AND STATE PROGRAMS

SEC. 201. (a) The Secretary shall coordinate Federal policies and programs providing services related to prevention of initial and repeat adolescent pregnancies. Among other things, the Secretary shall—

(1) require that grantees under title I report periodically on Federal programs or policies that interfere with the delivery and coordination of pregnancy prevention and pregnancy-related services to adolescents;

(2) provide technical assistance to assure that coordination by grantees of Federal programs at the local level will be facilitated;

(3) modify program administration or recommend legislative modifications of programs of the Department of Health, Education, and Welfare that provide pregnancy-related services in order to facilitate their use as a base for delivery of more comprehensive

pregnancy prevention and pregnancy-related services to adolescents;

(4) give funding priority, where appropriate, to grantees using single or coordinated grant applications for multiple programs; and

(5) give priority, where appropriate, to providing funding under existing Federal programs to projects providing comprehensive pregnancy prevention and pregnancy-related services.

(b) A State using funds provided under title I to improve the delivery of pregnancy prevention and pregnancy-related services throughout the State shall coordinate its activities with programs of local grantees, if any, that are funded under title I.

(c) The Secretary may set aside, in each fiscal year, not to exceed 1 per centum of the funds appropriated under this Act for evaluation of activities under titles I and II.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Honorable Harley O. Staggers
Chairman, Committee on Interstate
and Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your letter of April 25, requesting a report on H.R. 12146, the "Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978."

H.R. 12146 is identical to the bill which we transmitted to the Congress on April 13, with accompanying explanatory materials. This is the Administration's bill, except that two paragraphs were inadvertently omitted. The omitted language is enclosed with this letter. We request that the Committee amend the bill to cure this omission.

We urge prompt and favorable consideration of the bill, as amended.

We are advised by the Office of Management and Budget that the bill's enactment would be in accord with the program of the President.

Sincerely,

Secretary

Enclosure

Amendments to Administration's Draft Bill Entitled
"Adolescent Health Services and Pregnancy Prevention
and Care Act of 1978"

Insert at the end of section 104(a) the following new paragraphs:

"(12) assurances that the applicant will make every reasonable effort to collect appropriate reimbursement for its costs in providing services to persons who are entitled to have payment made on their behalf for such services under any Federal or other Government program or private insurance program; and

"(13) assurances that the acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service furnished by the applicant."

Strike the "and" at the end of paragraph (10) of section 104(a); and strike the period at the end of paragraph (11) of that section and insert instead a semicolon.

Mr. ROGERS. Now our first witness this afternoon is our distinguished colleague, the Honorable Tony Beilenson. He has had a great interest in this subject matter.

We are pleased to have you before the committee. If you could highlight your testimony for us, it will be helpful. Your statement will be made a part of the record in full at this point, without objection, and you may proceed as you would like.

STATEMENT OF HON. ANTHONY C. BEILENSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. BEILENSON. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I thank you for letting me testify before you today. As you may recall, I appeared before your subcommittee in late February of this year when you were considering the reauthorization of the title X program of the Public Health Service Act.

For those of you who were not present at that meeting and do not personally know me, I would like to share with you my background in the area of family planning. Before my election to Congress, I served 14 years in the California Legislature where, for 7 years, I was chairman of the Senate Committee on Health and Welfare and most recently, Chairman of the Senate Finance Committee. During my time in the legislature, I authored most of California's major family planning laws.

I now serve on the House Select Committee on Population, chaired by our colleague Jim Scheuer, where, along with Pete McCloskey, I co-chaired 9 days of hearings on fertility and contraception in the United States. These hearings, held 2 months ago, covered such topics as the effectiveness of existing Federal family planning services, the problem of adolescent fertility and pregnancy, and the safety and reliability of existing contraceptive methods. In addition, I introduced the bill, H.R. 11007, the "Comprehensive Family Planning Services, Research in Human Reproduction, and Prevention of Unwanted Teenage Pregnancy Act of 1978," which is essentially a rewrite of title X, the Federal family planning program.

Your subcommittee's Health Services Amendments of 1978, H.R. 12370, incorporated some of the changes in title X suggested in my bill and substantially increased the authorization levels for both preventive services and contraceptive research and placed an important emphasis on teenage pregnancy. It was only through the fine work of your chairman and your subcommittee that the title X program now has the potential to solve some of the serious problems we are here to discuss today.

The alarming facts about unwanted teenage pregnancies—and abortions—are undoubtedly well known to members of the committee. The Chairman has reminded you of some facts. I am certain that the other witnesses appearing before you today will remind you of those facts as well.

In the interest of time, I would like to directly address the legislation before us today the administration's Adolescent Health, Service, and Pregnancy Prevention and Care Act of 1978. I understand that this bill is only a portion of a larger $142 million

program that the administration is advocating—$60 million for the Adolescent Health, Services and Pregnancy Prevention Act of 1978 itself, and $82 million for proposed expanded services under medicaid, title X, community health centers and other existing Federal programs. I feel that it is important, however, to look at this bill apart from the entire package because it is unlikely, in this era of budget limits, that all $82 million for the proposed supplemental services will be appropriated by the Congress. I have chosen, therefore, to address myself solely to the merits of H.R. 12146.

I believe that the administration should be commended for recognizing the problems associated with adolescent child-bearing and for attempting to provide comprehensive services for these teenagers. This is the first time any administration has made a concerted effort to develop comphrehensive programs to help prevent unwanted pregnancies among adolescents and to help young mothers and their children, although this problem has plagued our society for many years. However, I have carefully read the bill and, with all due respect, while Secretary Califano's June 14th Senate testimony was compelling and compassionate, it did not address the specific issues with which your committee must concern itself today.

It seems to me this legislation raises a great many questions. Let me share with you some which have occurred to me.

In his testimony before the Senate Committee on Human Resources last week, Secretary Califano stated that, "Prevention is our first and most basic line of defense against unwanted adolescent pregnancies." While I agree wholeheatedly that prevention of unwanted pregnancies and births should be the major thrust of this bill, it seems to me that the bill falls short of insuring the success of that goal.

The first problem is that the proposed legislation fails to define any clear requirements for preventive services. Are preventive services limited to family planning, or are counseling and sex and family life education included as well? If an organization provides a single service, such as sex education, without family planning as well, will it be eligible for funds?

The Secretary also stated at last week's hearing that "a significant proportion" of the program budget will be allocated to projects providing preventive services. What is a "significant proportion"? Among those most interested in providing maternity benefits to already pregnant adolescents, a significant proportion of the budget may be only 10 percent. I think that the Secretary should be asked to explain what he means by a "significant proportion."

Unfortunately, we cannot help but be skeptical about the administration's intentions and commitment to prevention, since past efforts in this area have been less than aggressive. It has been the Congress which has called for increased funding for family planning and other preventive services, while the administration has thus far neither requested adequate funding for such services not supported such authorizations in Congress. It is difficult to understand why this longstanding position on the prevention of unwanted pregnancies would suddenly be reversed. If DHEW is truly emphasizing prevention as the overall theme for health care in this country, why was the substantial increase of funding for title X

pregnancy prevention services by this committee and the Senate not applauded? The Administration's demonstrated reluctance to emphasize contraceptive and other preventive services is disturbing.

There is another point that needs attention: Will provision of family planning services through this new legislation erode title X of the Public Health Service Act? Under the recent Senate authorization levels of title X, $35 million is available to provide family planning services to adolescents. Would the provision of similar services under this new legislation be a duplication of effort? Clearly, we would not like to see the new legislation construed as replacing title X. Rather, we would like to see it address itself to specific issues not covered by current title X regulations.

A good example of such an issue is family life and sex education. Programs in family life and sex education should be one of the primary strategies in the prevention of unwanted pregnancies and births. Unfortunately, this area has not been emphasized in the administration bill. While the administration may be avoiding this issue because of its perceived sensitivity, in fact it is not very controversial at all. It is a well-known fact that 77 percent of all Americans approve of sex education, and 90 percent of those approve of teaching about contraceptive methods in such courses.

Two weeks ago the Select Committee on Population held hearings on "A Variety of Approaches to Family Planning Services." We heard testimony about delivery of family planning services to teenagers from a variety of providers, all of whom oppose abortion. Each and every witness emphasized the fundamental need for family life and sex education as a prerequisite to the prevention of unwanted pregnancies among adolescents. They stressed the importance of counseling services in helping adolescents make decisions about whether or not they want to be sexually active. They all stressed that no single approach to sex education can be totally successful. This type of educational service requires the cooperation of parents, schools, churches, and community organizations; and, of course, funding.

Money is the one requirement that can be provided in this bill in order to promote family life and sex education. Such provision is not clearly defined, however. Instead, the bill states: "The services which may be included in such projects include, but are not limited to * * *" a variety of services, one of which is "education at the community level concerning sexuality and the responsibilities of parenthood * * *" Clearly, family life and sex education should be an integral part of any initiative aimed at the prevention of unwanted adolescent pregnancies. In the proposed legislation, this is not the case.

One final point on preventive services. Throughout the discussion of the prevention of unwanted pregnancies at both the Senate and select committee hearings, there seemed to be an underlying assumption that the problem and responsibility for its solution should focus upon the young adolescent woman. Since we are all well aware that young adolescent men are also involved, why aren't young men in our society accepting their share of the responsibility for being sexually active and participating in the prevention of unintended pregnancies? This program and, I might add,

other family planning programs have systematically ignored services for males. If this new program for the prevention of unintended pregnancies is to be innovative and effect change, an emphasis on the sexuality and responsibility of the adolescent male must be included.

Comprehensive Services

I would like to say a word here about comprehensive services. There is a reference throughout this bill to "comprehensive services," but the administration never defines what is meant by this. What do comprehensive services include? Will programs be required to deliver all of the defined comprehensive services in order to be eligible for funds? The issues are not addressed at all by the legislation.

There are several services which have not been included but which we feel should be fundamental in an initiative such as this. If the approach to services is to be truly comprehensive, the following services, at a minimum, should be required:

First, prevention (contraceptive services and sex education);

Second, early detection of pregnancy and referral for all types of counseling (ranging from abortion to adoption to keeping the child);

Third, maternity care for adolescents who choose to bring their pregnancies to term; and

Fourth, follow-up services such as vocational training, day care for infants, post-partum care for the mother, etc.

Obviously, this overall goal is unrealistic if only $60 million is to be appropriated.

The bill also discusses the issue of linkage of services versus provision of new services. The administration of proposing to spend half of the funds for "linkage of service," although there is no definition of what this linkage entails nor suggestion of what types of services should be linked. Furthermore, linking existing services presupposes that there are already services in communities to be linked.

While I agree that some coordination of existing programs for adolescents is needed, we suspect that the administration has overestimated the extent of existing services and thus, the possibilities for such linkage in most communities.

Funding

This brings me to the topic of program funding. H.R. 12146 authorizes $60 million for the purposes of this bill. At this low level, priorities for funding clearly will be necessary. HEW, however, has not as yet outlined how it plans to allocate the limited amount of money that will be available. Will the first priority be to coordinate existing services within communities or to establish and provide basic services in communities where such programs do not now exist? $60 million is simply not an adequate basis for solving the kinds of problems I think this bill was designed to alleviate.

In addition, HEW must indicate to Congress its intentions for future commitment to this program. Does the Secretary see this as a program which will continue for an indefinite period of time with substantial future increases in funding? Or will this act continue to

receive only the low level of funding requested for fiscal year 1979? If the latter is the case, the program will surely die of neglect; just as HEW's "alternatives to abortion" bill did earlier this Congress.

I have already alluded to the vagueness of the bill's language, particularly in terms of defining the intended goals. In light of the fiscal constraints under which both the administration and Congress are operating, I feel that clear definitions of the programmatic goals of this legislation are imperative in order to best utilize even the relatively small amount of money being considered here today.

ORGANIZATION

I would like to address myself to one final point—organization. Nowhere in this bill do we find out where in the Department of Health, Education, and Welfare the responsibility for this program would rest. Are we to assume, therefore, that there will be a special office within the Office of the Secretary that will administer this "adolescent initiative?" Frankly, the thought of a free-floating office within HEW's organizational structure worries me. I think that it should be made clear exactly who will be administering this program and to whom he or she will be responsible.

Another point concerns me even more, however. If this program is to deal with prevention even in part, why should this duty be placed within an office other than the already-created Office of Population Affairs, which currently has the responsibility for preventive services through the title X program?

The February 1978 DHEW report on Population and Family Planning Activities prepared for the House Committee on Appropriations states that:

"The Office of Population Affairs (OPA) serves as a focal point for coordination of Department population research, population education, and family planning service activities. The Deputy Assistant Secretary for Population Affairs (DASPA) heads the OPA and has full line authority and responsibility for directing population research and family planning services within the health agencies.

That seems to be fairly clear departmental policy.

It does not seem to be good management to make two separate offices within one department responsible for the same types of programs. Thus, the office that will have final decisionmaking authority for this program should be specified now.

I think that the intent of Congress was clear when the DASPA position was originally created in the 1970 title X legislation. Congress wanted the responsibility for family planning and educational services to be placed within OPA under the jurisdiction of the DASPA. I think it should remain there. I strongly believe that only the DASPA and the OPA can provide the kind of continuous and vigorous focus that the adolescent pregnancy dilemma requires. I also believe that the responsibility and authority for all population issues should lie in that office.

When responding to a question at last week's Senate hearing, Secretary Califano confirmed the importance of the DASPA position by indicating that he was interviewing candidates and was anxious to fill the position as soon as was possible. I think it would

clearly be counterproductive to appoint a strong DASPA—as I believe should be done—and then have the Secretary undermine that position by placing DASPA duties under another office.

CONCLUSION

I have had a difficult time keeping my remarks short, as you requested, since there is so much about the bill both to commend and to question; I have tried to at least highlight my thoughts on this legislation. However, there are many more issues that need addressing; issues on which I cannot claim to be knowledgeable. In addition, I believe that the witnesses here today are basically advocates of the legislation and are unlikely to question the initiative as a whole. So I would respectfully suggest that the committee consider having a second day of hearings on this bill. Another day of investigation would provide the committee with some answers to the many questions that should be raised today. It would also provide you with an opportunity to hear from some of the many groups that also have serious questions about this legislation.

I think we are all in agreement about what the bill intends to do, but I also think a lot of people have real questions about how HEW intends to go about solving the serious problem of teenage pregnancy.

Thank you very much for allowing me to testify before your committee today.

Mr. ROGERS. Thank you, Mr. Beilenson. We appreciate your giving us the benefit of your thinking. As we go along, we will be back to you with additional questions. Thank you so much.

Mr. SCHEUER. May I say one word?

Mr. ROGERS. Certainly.

Mr. SCHEUER. I wish to commend Congressman Beilenson for his superb testimony this morning and to thank him for the outstanding role he has played on the Select Committee on Population. He really did the preponderance of the work in organizing that committee's 3-week set of hearings. He organized them; he selected the witnesses, along with the staff, and, he chaired the hearings physically. I want to commend him for the length of time he has contributed.

Mr. ROGERS. The committee appreciates his interest. He has helped the committee before.

Mr. BEILENSON. Thank you very much.

Mr. ROGERS. Without objection, the Chair wishes to place in the record, as though read, the statement of Congressman William S. Cohen of Maine.

STATEMENT OF HON. WILLIAM S. COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. COHEN. Chairman Rogers and members of the Subcommittee on Health and the Environment, as you address the current problem of adolescent pregnancy, I take this opportunity convey to you my concern over this dilemma.

My active involvement with the problem of adolescent pregnancy began in 1975, when I worked with Senator Kennedy in drafting legislation to reduce the adversities associated with the escalating

number of adolescent pregnancies. The evidence documenting the need for such legislation is startling. Every year, 1 out of every 10 teenage girls in America becomes pregnant, a higher rate that that in 18 other developed countries. Almost one-third of these pregnancies involved girls giving birth out of wedlock, with 87 percent electing to keep their babies. Teenage sexual activity is increasing; more babies are being born to young mothers; young women overall have accounted for a larger proportion of all births. At the same time, the number of adolescents visiting clinics or private physicians for pregnancy prevention and pregnancy-related services represents only a small proportion of those in actual need of such services. In 1975, 1.6 million sexually active teenagers failed to visit a clinic or private physician for medical or counseling services. In my State, 20,000 females between the ages of 15 and 19, not being served by any organized programs, run the risk of an unintended pregnancy. Given the pandemic incidence of adolescent pregnancy today, if our legislative actions serve to curb the current number of unintended adolescent pregnancies, we will be providing a very valuable service to the uninformed adolescent and, at the same time, paving the way toward a definite solution to this problem.

Unwanted and unexpected pregnancies undermine the ability of young mothers to lead full and productive lives. Empirical studies indicate that the high incidence of pregnancy among this age group is due to the ignorance of pregnancy related information. I believe, therefore, that solutions to these problems are available and that with proper support we can deal effectively with adolescent pregnancy. An authorization of $60 million for this purpose has been requested by the President in the fiscal year 1979 budget. Recently, legislation was introduced in both chambers that would fulfill this budget commitment. The legislation would achieve our overall objective by encouraging the provision and coordination of comprehensive health education, medical, psychological, and other social services to adolescent parents and their children. Such a program would not only benefit the young mother and the family, but the entire cohort of individuals born to these young mothers. In Lewiston, Maine, a program called birth-line has been providing medical, psychological, and social services to approximately 125 adolescent females each year since March 1975, with voluntary support including a physician, two nurses, and two lawyers. The average cost per client is $325. Moreover, the program's role in the Maine community has been praised and its overall impact in Maine is best illustrated by a recent $5,000 grant from the city of Lewiston. We have seen that this type of program, providing these types of services, does work and should be instituted on a broader level.

I would like to call your attention to the bills presently under consideration in the Congress, S. 2910 and H.R. 12146, which provide for improved coordination of Federal and State programs. For the most part, these bills are identical. Both provide for grants which "plan for the administration and coordination of pregnancy prevention and pregnancy-related services for adolescents." Nevertheless, I would like to indicate my support for two modifications made to the Senate version of the bill, S. 2910, section 104(a) requirements for grant approval.

The first requires that there be assurances that the applicant for a grant make every reasonable effort to collect reimbursements for its costs in providing services to persons who are entitled to payments for such services under a Federal, other government, or private insurance program. As a member of the House Select Committee on Aging, I am cognizant of the duplication and fragmentation among Federal programs. I believe such a requirement is crucial if we ever hope to curb wasteful spending and rationalize our service delivery system. The stipulations under section 104(a) attempt to avert a duplication in spending and I support this wholeheartedly.

The same section of the Senate bill also requires that grantees provide assurances that acceptances of family planning services or population growth information (including educational materials) provided under this act by an individual be voluntary and not a prerequisite to eligibility or receipt of other services provided the grant applicant. This, in turn, would enable the adolescent to retain the right of personal choice in the matter and still qualify for the Federally sponsored program authorized by this legislation.

I firmly believe that any policy aimed at assisting pregnant adolescents must contain the flexibility to draw upon the available resources of the community. With our legislation establishing a focal point for these community services, our desire to reduce the current rate of adolescent pregnancy will make the best use of health centers, church groups, schools, and other community organizations to this end.

I intend to join with HEW and other concerned Members of Congress in the development of an effective and workable program, and I solicit the support of this committee for such legislation.

Thank you for allowing me to share my interest in your deliberations.

Mr. ROGERS. Our next witness will be Hon. Joseph Califano, Jr., Secretary of Health, Education, and Welfare.

We welcome you back to the committee. Your statement will be made a part of the record in full. You may proceed as you desire.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Secretary CALIFANO. Mr. Chairman, let me read certain portions of my statement and put it all in the record, if I may.

Mr. ROGERS. Certainly.

Secretary CALIFANO. I would like to thank the subcommittee for having this hearing, for beginning work on this legislation which we do consider important, and we hope it will be able to pass both the Senate and the House and become law this year.

Mr. Chairman, also this is my first public appearance before this subcommittee since you announced your intention to retire. I would like, on behalf of myself and everyone at HEW, to tell you while we respect your decision as an individual, we think that you have contributed as much to the health care in this Nation as any person in or out of the Congress and what is good about HEW, and you will be sorely and deeply missed as chairman of the subcommittee. As long as I am Secretary, I hope you will always be

around to help us keep these programs going and get them going better.

Mr. ROGERS. Thank you, Mr. Secretary, for your generous remarks.

Secretary CALIFANO. Mr. Chairman and members of the subcommittee, we meet in a moment when the headlines are filled with news of the taxpayers' revolt; a moment when public demands are growing more insistent that tax dollars, especially tax dollars spent for social programs, be spent with prudence and foresight. I believe the legislation on which I testify today promises to meet the test of being both compassionate and cost-effective.

For most of us, the birth of a child is an occasion of great joy and hope; an investment in the future; a consecration of life. But for hundreds of thousands of teenagers, particularly the majority who are unmarried, the birth of a child can usher in a dismal future of unemployment, poverty, family breakdown, emotional stress, dependency on public agencies, and health problems for mother and child.

Consider just a few of the consequences likely to befall a teenage mother and her child: Eight of ten women who have become mothers by age 17 never complete high school. Of all children born out of wedlock, almost 60 percent end up on welfare. Half of pregnant teenagers aged 15 to 17 receive no prenatal health care until the second trimester; 6 percent of pregnant teenagers under age 15 receive no prenatal care at all. A baby born to a teenage mother is more than twice as likely to die during the first year of life as a baby born to an older woman.

We cannot readily quantify many of the most searing consequences of unwanted teenage pregnancy: the despair of youngsters whose prospects are diminished; the corrosive effect on mothers and children of long-term dependency; the family instability which so often follows. But we can measure some of the costs to the mother, the child, and to our society that could be avoided if this program succeeds.

This issue of cost came up in the Senate, and these are some of the numbers we developed to answer some of the questions there. Each unwanted teenage pregnancy, for example, involves about $1,600 in prenatal, delivery, and postpartum service, that would be spent if the baby were carried to term. And there were almost 600,000 births to teenagers in 1976; many of them unintended.

The chances are disproportionately great that a baby born to a teenage mother will be low-weight at birth; more than one-third of the 57,000 low-birth weight babies born to teenagers each year require intensive care. This care costs roughly $600 per day for an average stay of about 13 days. For the 21,000 babies requiring this care in 1976, the total cost exceeded $163 million.

If the teenage mother and child go on welfare, they become public charges, with all the human and physical costs that this implies. If the program I describe today should help even one mother and child avoid welfare, the savings in AFDC, food stamps and Medicaid costs approach on the average $3,000 per year, and in some of the more generous States like Mr. Scheuer's home State of New York, probably $6,000 or $7,000 a year.

Mr. SCHEUER. At a minimum.

Secretary CALIFANO. At a minimum. I mention these numbers because I know there is great public concern about costs, but our main concern must be the burdens of human suffering and wasted potential that teenage pregnancies impose. When we consider the dimension of the teenage pregnancy problem, the need for this program becomes even clearer.

The age at which puberty occurs has declined steadily; largely reflecting improvements in nutrition. The average age of puberty in the U.S. today is 12.8 years for girls, but 13 percent reach puberty at age 11 or earlier. This means that some children reach the age of puberty in the fifth grade.

In 1976, 11 million teenagers age 15 to 19 had experienced premarital sexual intercourse at least once. For teenage girls in that age group, the number was 4.2 million. Forty percent of all girls 15 to 19, up from 30 percent in 1971. Two out of three boys in that age category had experienced premarital sexual intercourse, and approximately 375,000 girls under age 15.

Despite the fact that contraceptive use among teenagers is widespread and increasing and often effective, 25 percent of sexually active teenagers never use contraception. These adolescents who never use contraception are responsible for almost 60 percent of the premarital pregnancies among teenagers. In addition, 42 percent of those who do use contraceptives don't use them regularly. We estimate that about 1 million adolescent girls, 1 in 10 aged 15 to 19, as the chairman noted, become pregnant each year; the majority out of wedlock. Of these 1 million, 400,000 are 17 or under; 30,000 are 14 or under. While some teenagers are married and wish to become pregnant, a substantial number of teenage pregnancies are unwanted. More than 300,000 teenage abortions were reported in 1976 to the center for disease control.

Of these 1 million girls, 600,000 had their babies, and even though more than 40 percent, 235,000, of these babies are born out of wedlock, 9 out of 10 unmarried mothers decide to keep their babies; 560,000 of the 600,000 teenage mothers decide to keep their babies with them.

Scarcely anyone, liberal or conservative, permissive or restrictive, can read these figures about teenage pregnancy without a sense of shock and melancholy. Whatever our opinions about adult morality and sexual standards, it is sad to contemplate the specter of children being suddenly and prematurely faced with the responsibility of adults. But what some in our society choose to call sexual liberation has brought with it some unhappy consequences for millions of teenagers, the pressure to experiment with adult behavior before they are ready emotionally, morally; or physically to shoulder an adult responsibility; the wrenching disruption of life and education caused by unintended pregnancy and its consequences.

This is not liberation, Mr. Chairman. It is a form of bondage for the child-mother and for the mother's child. I am acutely aware that government cannot work miracles. We are confronting large social forces: Changing moral standards, declining authority in institutions like the church and the school, and a mass culture that treats sex not as a serious personal responsibility, often not even as an act of love, but as a glittering consumer item to be exploited.

Our society today is one in which personal self-discipline is more necessary than ever and less popular than ever. This means that there are limits to what government can accomplish. Nevertheless, I believe that a concerned and compassionate government should do what it can to reduce the social costs and the toll of human suffering caused by sexual activity and unintended pregnancies among teenagers.

This legislation constitutes an acceptance of that responsibility. It is important to stress at the outset that the administration's total initiative on teenage pregnancy is much broader than this bill. We have proposed as part of the 1979 budget an expansion and targeting on teenagers of a number of existing programs such as family planning, Medicaid, maternal and child health care, community health centers, education, and HEW-funded research. In fiscal 1979, we requested a total of $344 million for teenage pregnancy and its related problems; a $148 million increase over the prior year.

The basic elements of this legislation can be briefly summarized. It authorizes HEW to make grants for up to five years to groups committed to two purposes: preventing unintended teenage pregnancies and helping those teenagers who become pregnant. Grantees may be State and local agencies, community health centers, family planning clinics, schools, churches, teenage centers, residential care facilities, and other such groups.

In order to qualify for a grant, local projects will have to document the magnitude of the teenage pregnancy problem in their communities, describe the resources already available to address it, discuss the way in which they will link and improve these resources, and provide a plan for evaluating the effectiveness of their efforts.

The legislation requires federal and state programs relating to adolescent pregnancy to be better coordinated at both levels and requires HEW to evaluate activities under the Act.

The program is based upon four core principles: First, it pursues a pair of closely related goals: the prevention of unintended adolescent pregnancies, and the care of pregnant teenagers and their babies.

The second purpose is to encourage expanded and comprehensive services for adolescents who are at risk of initial and repeat pregnancies or in need of pregnancy-related care.

One of the main target groups, Mr. Chairman, is the teenager who has had a baby. Twenty-five percent of them, with all family planning and abortion services available, will have a child within a year; something approaching 70 percent within 2 years a second child.

Third, this legislation encourages local experimentation with a variety of innovative approaches to designing, delivering, and coordinating pregnancy prevention and care in ways suited to local needs.

Fourth, this legislation builds, to the maximum extent possible, upon existing resources and institutions at the Federal, State, and local levels.

Mr. Chairman, there are other points at the end of my testimony, but I am sure they will almost certainly come up in the question period.

[Testimony resumes on p. 32:]

[Mr. Califano's prepared statement follows:]

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman; members of the subcommittee; I'm pleased to appear this afternoon to testify in support of the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978.

We meet, Mr. Chairman, at a moment when the headlines are filled with news of a taxpayer's revolt: a moment when public demands are growing more insistent that tax dollars—especially tax dollars spent for social programs—be spent with prudence and foresight.

I believe all of us in public service share this concern of the Nation's taxpayers. Indeed, it is my strong conviction that government can and must be as efficient as it is compassionate.

The legislation on which I testify today promises to meet that test: to be compassionate—and cost-effective.

The basic purpose of this act is to reduce the human suffering occasioned by an epidemic of teenage pregnancies in America. But we have drafted it in full awareness that you in the Congress are deeply concerned about the cost of public programs. We believe this legislation can help reduce the welfare costs, health-care costs, the costs of dependency and unemployment that so oten are the aftermath of adolescent pregnancies.

For most of us, the birth of a child is an occasion of great joy and hope, an investment in the future, a consecration of life. But for hundreds of thousands of teenagers—particularly the majority who are unmarried—the birth of a child can usher in a dismal future of unemployment, poverty, family breakdown, emotional stress, dependency on public agencies, and health problems for mother and child.

Consider just a few of the consequences likely to befall a teenage mother and her child:

Eight of ten women who have become mothers by age 17 never complete high school.

Of all children born out-of-wedlock, almost 60 percent end up on welfare.

Half of pregnant teenagers age 15–17 receive no prenatal health care until the second trimester; 6 percent of pregnant teenagers under age 15 receive no prenatal care at all.

A baby born to a teenage mother is more than twice as likely to die during the first year of life as a baby born to an older woman.

The annual earnings of a woman who has her first child at age 15 or below are roughly 30-percent less than the earnings of a woman who has first child at 19 or 20.

A girl who marries at age 14 to 17 is two to three times more likely to experience divorce or separation than one who marries in her early 20's.

We cannot readily quantify many of the most searing consequences of unwanted teenage pregnancy—the despair of youngsters whose prospects are diminished; the corrosive effect on mothers and children of long-term dependency; the family instability that so often follows. But we can measure some of the costs to the mother, the child, and to our society that could be avoided if this program succeeds:

Each unwanted teenage pregnancy, for example, involves about $1,600 in prenatal, delivery, and postpartum service, that would be spent if the baby were carried to term. And there were almost 600,000 births to teenagers in 1976, many of them unintended.

The chances are disproportionately great that a baby born to a teenage mother will be low-weight at birth—more than one-third of the 57,000 low-birth weight babies born to teenagers each year require intensive care. This care costs roughly $600 per day for an average stay of about 13 days. For the 21,000 babies requiring this care in 1976, the total cost exceeded $163 million.

Low-birth weight babies are more likely to suffer from any of several handicapping conditions, such as epilepsy, mental retardation, malformation, and brain damage. Providing special services to such unfortunate children is expensive: special education alone, for example, averages about $1,700 per child per year more than the cost of normal education.

32-704 O - 78 - 3

If the teenage mother and child go on welfare, they become public charges, with all the human and fiscal costs that this implies. If the program I describe today should help even one mother and her child avoid welfare, the savings in AFDC, food stamps, and medicaid costs approach $3,000 per year. And in 1975, there were over 250,000 teenage mothers with at least one child on AFDC.

These are of course only examples of areas where there are potential savings. They suggest, however, that this legislation can be not only humane but highly cost-effective as well. I mention these figures because I know there is great public concern about costs—but our main concern must be the burdens of human suffering and wasted potential that teenage pregnancies impose. And when we consider the dimensions of the teenage pregnancy problem, the need for this program becomes even clearer:

The age at which puberty occurs has declined steadily, largely reflecting improvements in nutrition. The average age of puberty in the United States today is 12.8 years for girls, but about 13 percent reach puberty at age 11 or earlier. This means that some children reach puberty by the fifth grade.

In 1976, 11 million teenagers aged 15–19 had experienced premartial sexual intercourse at least once. For teenage girls aged 15–19, the number was 4.2 million: 40 percent of all girls 15–19—up from 30 percent in 1971. Two out of three boys in that age category had experienced premartial sexual intercourse—and approximately 375,000 girls under age 15.

Despite the fact that conceptrative use among teenagers is widespread, increasing, and often effective, 25 percent of sexually active teenagers never use contraception. These adolescents who never use contraception are responsible for almost 60 percent of the premartial pregnancies among teenagers. In addition, 42 percent of those who do use contraceptives don't use them regularly.

We estimate that about 1 million adolescent girls—1 in 10 aged 15–19—become pregnant each year, the majority out of wedlock. Of these 1 million girls, 400,000 are 17 or under; 30,000 are 14 or under. While some teenagers are married and wish to become pregnant, a substantial number of teenage pregnancies are unwanted; more than 300,000 teenage abortions were reported in 1976 to the Center for Disease Control.

Of these 1 million girls, 600,000 have their babies. Even though more than 234,000 of these babies are born out of wedlock, 9 out of 10 unmarried mothers decide to keep their babies.

Scarcely anyone—liberal or conservative, permissive or restrictive—can read these figures about teenage pregnancy without a sense of shock and melancholy. Whatever our opinions about adult morality and sexual standards, it is sad to contemplate the specter of children being suddenly and prematurely faced with the responsibilities of adults.

What some in our society choose to call sexual liberation has brought with it some unhappy consequences for millions of teenagers: the pressure to experiment with adult behavior before they are ready—emotionally, morally, or economically—to shoulder adult responsibility; the wrenching disruption of life and education caused by an unintended pregnancy and its consequences. This is not liberation; it is a form of bondage for the child-mother and the mother's child.

I am acutely aware, Mr. Chairman, that government cannot work miracles. We are confronting large social forces: changing moral standards, the declining authority of institutions like the church and the school, and a mass culture that treats sex not as a serious personal responsibility—often not even as an act of love—but as a glittering consumer item to be exploited. Our society today is one in which personal self-discipline is more necessary than ever—and less popular than ever.

This means that there are limits to what government can accomplish. Nevertheless, I believe that a concerned and compassionate government should do what it can to reduce the social costs and the toll of human suffering caused by sexual activity and unintended pregnancies among teenagers.

This legislation constitutes an acceptance of that responsibility. It reflects what we believe is a consensus among knowledgeable prople who work in the field of adolescent health and teenage pregnancy. Our bill also draws upon legislative proposals that have been previously advanced.

It is important to stress at the outset that the administration's total initiative on teenage pregnancy is much broader than this bill. We have proposed as part of the 1979 budget an expansion and targeting on teenagers of a number of existing programs, such as family planning, medicaid, maternal and child health, community health centers, education, and HEW-funded research. In fiscal 1979, we have requested a total of $344 million for programs to address the pressing problems of teenage pregnancy: an increase of $148 million over current efforts.

The basic elements of this legislation can be briefly summarized:

It authorizes HEW to make grants for up to 5 years to groups committed to two purposes: preventing unintended teenage pregnancies, and helping those teenagers who become pregnant. Grantees may be State and local agencies, community health centers, family planning clinics, schools, churches, teenage centers, residential care facilities, and other such groups.

In order to qualify for a grant, local projects will have to document the magnitude of the teenage pregnancy problem in their communities, describe the resources already available to address it, discuss the way in which they will link and improve these resources, and provide a plan for evaluating the effectiveness of their efforts.

The legislation requires Federal and State programs relating to adolescent pregnancy to be better coordinated at both levels and requires HEW to evaluate activities under the act.

The program is based upon four core principles:

First, it pursues a pair of closely-related goals—the prevention of intended adolescent pregnancies, and the care of pregnant teenagers and their babies.

Prevention is our first and most basic line of defense against unintended adolescent pregnancies. The Department's preventive strategy takes several forms, including education on the responsibilities of sexuality and parenting, family planning services, and large increases in research directed at prevention.

We anticipate that a significant portion of the $60 million budgeted for our proposed program will go to projects providing such family planning and educational services. In addition, we have budgeted for substantial increases in fiscal 1979 in family planning for teenagers in the title X, community health centers, and maternal and child health programs, as well as expanding medicaid coverage (including family planning) for approximately 280,000 teenage women.

But when, despite our efforts at prevention, these young people do become pregnant and decide to give birth, our concerns must shift: we must insure that both mother and child are healthy, and that the new family can strive toward a self-sufficient and productive future. And we must attempt to prevent the unwanted second and third pregnancies which often quickly follow the first.

Achieving these objectives will require a variety of services: prenatal care, parenting, and other education, and job counseling, as well as primary prevention services. By combining both approaches, this legislation, we believe, gives us a more effective prevention strategy.

The second purpose of this act is to encourage expanded and comprehensive services for adolescents who are at risk of initial and repeat pregnancies, or in need of pregnancy-related care.

Let me emphasize the word *comprehensive.* Almost all people with experience in dealing with the problem agree that for many adolescents, only comprehensive services will succeed in achieving the objectives I have just discussed.

Many adolescents who will not seek family planning help on their own can be attracted by other services, such as health care, counseling, or legal services. Those who have long experience with comprehensive teenage programs tell us that quite a few teenagers who receive contraceptive information and counseling originally came seeking other services, such as vocational or legal counseling, social services, or recreation. In particular, such comprehensive services can attract teenage boys into prevention and care programs, an important part of any solution.

What do we mean by comprehensive services? Let me cite some examples. The center for school age mothers and their infants, a comprehensive center associated with the Johns Hopkins Medical Center in Baltimore, provides pre- and post-natal care, primary health care, vocational counseling, family planning, parenting education, and other services. This program has demonstrated considerable success in reducing the incidence of low-birth weight babies, school dropouts, and repeat pregnancies.

A similar program, The New Futures School in Albuquerque, has reduced the 1-year repeat pregnancy rate to only 8 percent. And more than 70 percent of mothers in the program return to school after the birth of their child.

The work done by other programs, such as the Brookside Family Life Center in Boston and the four centers of the Delaware adolescent program, suggest that a comprehensive approach—including education, day care, medical care and social services—can yield the most successful results.

Third, this legislation encourages local experimentation with a variety of innovative approaches to designing, delivering, and coordinating pregnancy prevention and care in ways suited to local needs.

Clearly, there is no single answer to the adolescent pregnancy problem. We are convinced that successful approaches will be devised in local communities, not in Washington. For this reason, the bill provides flexibility to fund different types of grantees with different approaches, different emphases, and different mixes of services. This diversity will insure that the program is not locked into a single type of service delivery system, and it can be tailored to the needs of particular communities.

Fourth, this legislation builds, to the maximum possible extent, upon existing resources and institutions at the Federal, State, and local levels.

The $60 million authorized by this legislation will not go very far unless it is used to call forth additional funds from other programs and sources: Federal, State, and local. The bill specifically requires this. Where pregnancy prevention and care programs already exist in a community, the bill will primarily encourage links between them and strengthen those links where needed. When a community lacks essential services, however, program funds may be used to provide them. The bill specifically provides for a gradual decline in Federal support for particular projects; the purpose of this provision is to stimulate the local support which alone can insure success. We will, however, be flexible about this requirement and permit adjustments in appropriate cases.

Let me turn now to two questions that have been raised about this legislation.

First, why new legislation? Can't these purposes be achieved under existing programs?

Our considered judgment, Mr. Chairman, is that the purposes I have outlined cannot be achieved very well—if at all—under existing programs:

To begin with, many existing programs have rather narrow categorical orientations. This legislation, we believe, provides a way of linking these separate programs in a broader effort. This bill, as someone has put it, provides the "glue" for uniting separate efforts and providing the multiple services that adolescents need.

Moreover, while existing agencies—title X projects, community health centers, maternal and child health clinics—would be eligible for grants under this law, we want to give local communities, where they have the ability, the freedom to choose other kinds of providers as well to pull together the necessary services: schools, church groups, or community organizations, for example.

A second question concerns the projected cost of services for each client. This cost, of course, will depend critically on the mix of services provided. In existing programs, the range is great—from approximately $100 for primary prevention projects involving family planning services, counseling and education, up to $1,600 for a broad array of services for pregnant teenagers, their babies and families. For five centers we surveyed which offer a reasonable range of services, however, average cost is approximately $750 per client. And I want to stress that in many cases the "client" receiving these services will be not an individual but a family: a mother, her child, and even the child's father.

In addition, services such as prenatal health care, delivery, postpartum and infant day care would, in many cases, be paid for by medicaid, maternal and child health, title XX, and other existing programs.

Mr. Chairman, adolescent pregnancy is one of the most complex, persistent, and poignant problems facing our society today. The power which government possesses to deal with it, I must emphasize, is limited. Nonetheless, we believe that this administration legislation—the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978, together with the Department's expansion and retargeting of existing programs—represents an important start toward effective solutions. The cost of the program, we think, is entirely justifiable—especially when measured against the far greater and harsher costs of simply maintaining our current efforts.

The role of government must necessarily be limited when we approach a problem that deals with private lives and behavior. But when the social costs and consequences of a problem are so great, we must not fail to take what steps we can. This legislation represents our effort—a carefully constructed and long-considered effort—to take those steps.

We are gratified by the support that this initiative has already attracted among members of the Congress and we intend to work closely with the Congress in the coming months to insure passage of this legisltion.

Mr. ROGERS. Thank you, Mr. Secretary, for a very helpful statement.

May I ask, is there any reason not to include infant day care services in this proposal?

Secretary CALIFANO. No. Day care services are included and could be funded. The Federal Government spends something over $2 billion, on day care now. The country spends another $6 billion privately, or more. We would hope to try to use some of this money to glue day care services, for example, to a community health center.

Mr. ROGERS. I think it would be well to explain that for the record.

Secretary CALIFANO. Fine, Mr. Chairman. [See p. 34.]

Mr. ROGERS. Finally, my last question: Should there be a defined minimum core of services in order to qualify for this program? Many people have expressed concern to staff about the lack of definition in this proposal.

Secretary CALIFANO. Mr. Chairman, we provide a range of services on the bill, but I would suggest that the Secretary at least be given authority to make exceptions to that. My concern is in rural areas. The mental health program suffers badly because of the requirements that we have to have in every community a mental health center. As a result, rural areas are badly served because there are few centers that can meet all those requirements.

Mr. ROGERS. I am going to ask members to question the Secretary quickly, since we were late in getting started. The second bells have just rung. Could members submit questions to the Secretary and have him answer them for the record?

Is there any objection to that?

Mr. SCHEUER. I object to it, Mr. Chairman. I don't want to be difficult, but this is a very important bill.

Mr. ROGERS. I think it will be 30 to 45 minutes before we return. There are six votes.

Mr. SCHEUER. Maybe we ought to adjourn and ask the Secretary to come some other time.

Mr. ROGERS. Perhaps we could. I thought we wanted to get busy on the bill and get it out. I wondered if we could do it by a process of submitting written questions to the Secretary.

Mr. SCHEUER. If the Secretary prefers that, I will be happy to go along. I think it is always better that we ask the witness the questions.

Mr. ROGERS. I prefer that. It may be that we will need to work out another session. If we could at this time perhaps, if it is satisfactory, proceed on that basis.

Mr. SCHEUER. I will withdraw my objection. I think that informally, if we decide we need more conversation with the Secretary, he will come back.

Mr. ROGERS. That will be satisfactory?

Secretary CALIFANO. Absolutely.

[Testimony resumes on p. 52.]

[The following letters and attachment were received for the record:]

NINETY-FIFTH CONGRESS

PAUL G. ROGERS, FLA., CHAIRMAN

DAVID E. SATTERFIELD III, VA.
RICHARDSON PREYER, N.C.
JAMES H. SCHEUER, N.Y.
HENRY A. WAXMAN, CALIF.
JAMES J. FLORIO, N.J.
ANDREW MAGUIRE, N.J.
EDWARD J. MARKEY, MASS.
RICHARD L. OTTINGER, N.Y.
DOUG WALGREN, PA.
HARLEY O. STAGGERS, W. VA.
(EX OFFICIO)

TIM LEE CARTER, KY.
JAMES T. BROYHILL, N.C.
EDWARD R. MADIGAN, ILL.
JOE SKUBITZ, KANS.
SAMUEL L. DEVINE, OHIO
(EX OFFICIO)

ROOM 2415
RAYBURN HOUSE OFFICE BUILDING
PHONE (202) 225 4952

Congress of the United States
House of Representatives
Subcommittee on Health and the Environment
of the
Committee on Interstate and Foreign Commerce
Washington, D.C. 20515

July 17, 1978

The Honorable Joseph Califano, Jr.
Secretary
Department of Health, Education
and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

At the conclusion of your testimony on Wednesday, June 28, 1978, concerning H.R. 12146, the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978, it was agreed that Members of the Subcommittee would submit their questions to you for written response for the Hearing Record.

Enclosed are those questions which have been posed by Subcommittee Members. In addition, I would request the Department's written comments on the concerns raised by Congressman Beilenson in his testimony before the Subcommittee. A copy of Mr. Beilenson's testimony is also enclosed.

Your prompt attention to these questions will be most appreciated.

Kind regards.

Sincerely yours,

PAUL G. ROGERS, M.C.
Chairman, Subcommittee on
Health and the Environment

PGR:aj

Enclosures

[Questions submitted by the Subcommittee and Secretary Califano's responses follow:]

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

AUG 17 1978

The Honorable Paul Rogers
Chairman, Subcommittee on Health
Committee on Interstate
and Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Paul:

Thank you for your letter providing me with the opportunity to respond to Representative Beilenson's testimony as well as the questions posed by Members of the Subcommittee. I regret it was not possible for me to respond directly at the hearing, but I am appreciative of your consideration.

I believe that the enclosed responses address all of the concerns raised. If there are additional questions, I would also be delighted to respond to them.

Enactment of this legislation this session is important. It would provide a vehicle for addressing in a comprehensive fashion, the need to assure prevention of teenage pregnancy and provision of comprehensive services to teenagers who, for one reason or another, become pregnant. I am convinced that the money spent in our proposed adolescent pregnancy initiative represents an important cost-effective investment in our future.

I am grateful for your assistance and cooperation. We look forward to working with you in assuring enactment of this much needed legislation.

Sincerely,

Joseph A. Califano, Jr.

Enclosure

Question No. 1

In your testimony before our Subcommittee, you stated that, "Prevention is our first and most basic line of defense against unwanted adolescent pregnancies." While we all agree with the importance of prevention in this area, the legislation fails to define any clear requirements for preventive services. For example, are preventive services limited to family planning, or are counseling, family life and sex education programs included as well?

Answer

Family planning would be only one of the preventive services eligible for funding. Other preventive services, such as counseling, family life and sex education, and education for parenting may also be funded.

Question No. 2

You also stated at our hearing that "a significant proportion" of the program budget will be allocated to projects providing preventive services. What do you define as a "significant proportion?"

Answer

Both pregnancy prevention and support for pregnant adolescent are primary goals of the new grant program.

While we will encourage programs to address both the need for prevention and support, we cannot predict how the $60 million will be divided since this will depend upon what communities consider to be their high priority needs. However, each funded project will be required to have a prevention component may serve only those who are already pregnant by providing services to avoid repeat pregnancies.) Because one objective of the project grant program is to discover what kinds of prevention and supportive projects work, we will fund a variety of different kinds and combinations of programs.

Question No. 3

I also believe that an integral part of adolescent pregnancy prevention is family life and sex education. Unfortunately, this area has been emphasized enough in the Administration's overall adolescent initiative. How much of the $60 million will be devoted to the area of family life and sex education programs? What do you intend to accomplish with this amount of funding?

Answer

We cannot state specifically how much of the $60 million will be devoted to family life and sex education programs because each community will be able to decide on its own special emphasis. In some communities, a high priority may be given to establishing extensive community and school-based education programs; other communities might use their project grant funds to help coordinate the development of such programs, but the actual funding might come from other sources.

While we cannot tell in advance how much money will be spent on sex and family life education, we can say that we will encourage all applicants to include some type of community/school based sex education for parenthood, and family life education as an integral part of their comprehensive prevention and support program.

We hope to accomplish an increase in family life and sex education programs in communities in which there are HEW-funded projects.

Question No. 4

Throughout the discussion of the prevention of unwanted pregnancies, there seems to be an underlying assumption that the problem of responsibility for its solution should focus on the young adolescent woman. Why have the needs and responsibilities of the young adolescent males been generally ignored by the Administration's programs?

Answer

Although a few programs have begun to include some type of male strategy, there is not wide agreement on how teenage males should be approached. Current efforts in family planning programs have not been particularly

successful, although there is male involvement in some comprehensive programs. A recent HEW study on family planning services showed that programs differed on whether males should have separate clinics, should be the focus of outreach, should be approached through a wider distribution of birth control devices such as condoms, etc. One thing agreed upon, however, was the fact that teenage males must be involved in the program.

Comprehensive Adolescent Pregnancy Centers have had considerable success in working with males for the following reasons:

1. Programs recognize the need to involve males and invite them to participate in program activities from the very beginning, along with the adolescent female.

2. Most programs have staff who have been especially trained to work with both the adolescent female and the male. Consequently, it is generally easier for such staff to relate to the male and provide counseling related to his sexuality and need for family planning services.

3. Males often come to the center to see what their girlfriends are involved in and can be more easily drawn into counseling sessions and classes.

4. Males also frequently bring their male friends along with them to the centers. "Rap" sessions can more easily be initiated around sexual responsibility and do frequently occur.

Comprehensive Adolescent Pregnancy Programs involve males in the following kinds of activities:

1. Counselling sessions about pregnancy prevention and sexual responsibility. These sessions are held with males alone, and also with males and females together.

2. Group "rap" sessions with both fathers and non-fathers regarding pregnancy prevention.

3. Social workers assist the males in continuing with their education, enrolling in vocational education and manpower training programs, finding and holding jobs, budgeting their personal funds, etc.

4. Prospective fathers participate in the following kinds of activities:

   a) The mother's preparation for childbirth
   b) His presence in the delivery room itself
   c) Parenting instruction
   d) Relationship between adolescent mother and father
   e) Family problems that may result from pregnancy
   f) Legal concerns of the male
   g) Financial responsibilities to the child.

Under our new legislation, we will be asking each program to describe how they propose to deal with adolescent males. The legislation has been drafted with a broad mandate for innovative program development to allow communities to experiment and develop approaches to adolescent males which best work in their communities. From these experiences, as well as what we learn from the limited number of programs already involved in this area, we will work to stimulate interest in expansion of this area and to share with communities the results of the various program approaches.

Question No. 5

There is much discussion in your bill about "comprehensive services", yet this is never defined. What do comprehensive services include? Will programs be required to deliver all of the defined comprehensive services in order to be eligible for funds?

Answer

Programs will not be required to offer all services in order to be eligible for funding. However, priority will be given to those programs which demonstrate the capability of bringing together a broad array of services. Programs will develop the services which are needed by their community to ameliorate the problems of adolescent pregnancy.

In regard to comprehensive service programs for pregnant adolescents, the following components are among those which could be included:

(a) Early and Continuing Prenatal Care

(b) Health related education

(c) Social Services

(d) Comprehensive Health Care For The Infant

(e) Long Term Follow-Up Services

(f) Education, both Vocational and Parenting

(g) Infant Day Care

(h) Ways of Including Fathers

(i) Involvement of Community

(j) Staff Training and Education

(k) Transportation

(l) Evaluation

In regard to comprehensive prevention programs, the following types of services are among those which could be included:

(a) family planning services for females and males

(b) education concerning sexuality and the responsibility of parenting

(c) screening and treatment of venereal disease

(d) referrals for medical and non-medical problems

(e) Counseling of females and males around special needs relating to their sexuality

(f) community outreach programs

(g) community involvement

(h) staff training and education

(i) evaluation

Question No. 6

The bill also discusses the spending of half of all the funds for "linkage of services" although there is neither definition of what linkage entails, nor suggestion of what types of services should be linked. Linking of existing services assumes that there are already community-based services to be linked; however, I suspect that the Administration has over-estimated the extent of existing services. Has the Administration assessed the extent and quality of existing services? Could the Administration provide us with detailed information on the estimated need for various adolescent services, the extent to which these needs are now being met, and the extent to which the Administration's overall initiative will provide the needed services? In view of the lack of services in many of these areas, isn't it more reasonable to allocate at least 75 percent of the $60 million for direct services to teenagers and only 25 percent of the money for the linkage of those services?

Answer

The major purpose of the new legislation is to ensure that more services are available to adolescents. We learned in developing this proposal that there are large gaps in the current service delivery system and that federal leadership is needed to aid communities in their efforts. However, we should not develop a new service delivery system geared solely towards the needs of adolescents and the problems associated with pregnancy. We already have many health care, education, social services, and income support programs, like Medicaid, Maternal and Child Health, BEOG's, Title XX Social Services, AFDC, and CETA. We do not want to duplicate services that are already available.

Rather, we want to help adolescents get greater access to available services and to increase use of entitlement programs. The funds which are earmarked for improved linkages and coordination should do just that — ensure that a young person seeking one service is informed about and provided access to other relevant services. These funds should have a multiplier effect in terms of local, State, and federal resources.

We recognize, however, that in some communities, many services are not currently available and will need to be provided through project grant funds. In such cases, the bill allows the Secretary to waive the limitation on funds for direct services.

Question No. 7

The language of this bill is very vague especially with reference to defining intended goals. What exactly do you intend to accomplish with this program? What efforts have been made to evaluate whether those goals are being met? Should the percentage of money allocated to the evaluation of these programs be increased from at least one percent of the overall budget to at least three percent?

Answer

We hope to be able to reduce the rate of first time adolescent pregnancies, improve services for teenagers already pregnant, reduce repeat pregnancies, and enable adolescents to become productive members of communities.

Standard practice is for an allocation of one percent of program funds to be made available for evaluation. Funds may also be available from other offices for evaluation purposes.

Question No. 8

Wouldn't it be advisable to eliminate the need for OMB clearance for the Center for Population Research contract projects and the evaluation projects for the Adolescent Health, Services, and Pregnancy Prevention Initiative?

Answer

The Select Committee on Population brought the problems described in this question to our attention. We recognize that in the past there were difficulties in administrative delays associated with clearance of public use reporting forms. In part this was due to the cumbersome clearance process and in part because the Center for Population Research faced additional difficulties by the nature of its subject matter and the sensitivity to considerations of personal privacy in fertility and sexuality studies.

We are confident that a statutory exemption is not needed because of the high priority the Department is according to this research and the Secretary's personal commitment to ensuring this research is undertaken expeditiously. In addition, certain administrative difficulties have been eased somewhat. HEW is currently conducting an intensive program to reduce the public burden associated with public use forms. As a result of this program, a separate layer of review for all forms (new and old) has been created within the Office of the Secretary (ASMB). This additional layer of review has temporarily slowed the review process; however, all reviews pursuant to this one-time effort should be completed by September. Reflecting on the effect of these reviews, PHS eliminated 21 reports and reduced the burden of 14 others for a total reduction of more than 300,000 burden-hours during the first six months of FY 77.

In order to give immediate relief to the PHS clearance process, we have authorized the PHS reports clearance signature authority to be delegated one level below the Assistant Secretary for Health. This authority was granted on May 31, 1978, and should speed up the clearance process by at least one week.

The Assistant Secretary for Management and Budget is presently developing new reports clearance procedures which will eliminate the need to forward the vast majority of PHS reports to the Office of the Secretary for clearance. These procedures will commence after the burden reduction program is completed; they should eliminate from one to two weeks from the clearance process. OMB has taken active steps to eliminate lengthy delays in their reviews. Specifically, in February, they established a policy of accepting agency approval on all "small burden" forms (20,000 forms and less than one-half hour in questions) in order to eliminate redundant detailed reviews. In addition, OMB has indicated that on any form on which expedited clearance is requested, OMB will provide special handling.

Question No. 9

The bill does not specify the location within DHEW of responsibility for administering this program. If this program is to deal with prevention even in part, should not this responsibility be placed under the DASPA and in the Office of Population Affairs, which currently has the responsibility for preventive services through the Title X program? Congress has mandated that responsibility for family planning and educational services be placed within OPA under jurisdiction of the DASPA.

Answer

The program will be managed by a Director who will report to the Assistant Secretary for Health and will work in close cooperation with the Office of the Deputy Assistant Secretary for Population Affairs.

The placement of the Office in the Public Health Service does not indicate an exclusive or even a primary health emphasis, however. In its administration, Departmentwide coordination will be effected. Development of program policies, the grant review process and program and project evaluation will involve substantive participation of the Office of the Assistant Secretary for Human Development Services and the Education Division.

Question No. 10

Since Dr. Nix assumed the position of coordinator for the Department's Teenage Pregnancy Initiative, it is my understanding that she has convened an informal advisory committee which met on May 1 and again on June 7. What is the function of the Committee and who are its members? On what basis were the members selected for participation? Will this Committee have a continued role in future activities relating to the Teenage Pregnancy Initiative?

Answer

An Ad Hoc Committee was organized this spring not by Dr. Nix but by two directors of adolescent programs outside the Department. They feel that the group serves four important functions:

1) to establish an informal group through which they could share problems and concerns regarding adolescent pregnancy;

2) to gain greater understanding of programs on the federal level which have an impact on adolescents and their families;

3) to provide HEW with their expertise in the field;

4) to provide information from the field to HEW on the needs of adolescents, methods of serving them, ways to develop or improve linkages of services within their communities, and other concerns.

Although they met at HEW and Department staff observed and participated in portions of their meetings, this group was not under HEW sponsorship or auspices. We anticipate that their individual expertise may be utilized in the same manner in the future. We intend to seek advice from all interested and concerned groups regarding the implementation of the legislation.

Question No. 11

Each year there are about 145,000 births to teenagers in need of comprehensive services. If the Federal government were to provide comprehensive services to all of these young women in need, the cost would be upwards of $400 million based on per patient cost estimates of $2,000 for the Johns Hopkins program. Is the Administration willing to recommend to Congress a program for services for pregnant adolescents at this level of funding? Would you be willing to phase in such a program over a period of 3 years? If not, wouldn't the $60 million you are proposing be better spent in providing a variety of services for the prevention of teenage pregnancies, many of which (like contraceptive counseling and services provided in a free-standing family planning clinic) can be provided for a small fraction of the per patient cost of comprehensive services?

Answer

The provision of Comprehensive Services to pregnant teens is an expensive service. It is not, however, the primary purpose of the Administration's proposal to provide all the Comprehensive Services needed by adolescents with the $60 million requested. The primary intent of the Administration's Bill is to establish better linkages by which these comprehensive services can be provided to adolescents and paid for by other funding sources such as Medicaid, Title XX and local community funds where available. In communities where there are no such services, it is the intent of the bill to establish programs that will provide these services. We do not anticipate that a network of linkages will be so completely established during the first and second years as to achieve the desired results of providing comprehensive services. Therefore, our request for $60 million is, indeed, a phasing-in program. Although we believe that prevention is one important way we can help teenagers, it is an incomplete solution however. (See question #16).

However, most programs cost considerably less than $2,000 per participant. For example, we know that for five centers which offer some of a variety of services that should be provided in projects funded under the new legislation, the average cost for some of the services is approximately $750 per client. These services include: special instruction for teenage parents; educational and vocational counseling; health counseling; well-baby care; counseling to adolescent mothers, fathers, and the parents of the adolescents; social services for pregnant girls and followup services for adolescent mothers; infant day care; family planning to avoid repeat pregnancies; and pregnancy prevention outreach to those not in the program.

The $750 average cost does not cover provision of all services. If a single program offered all these services (listed above) plus psychological testing, meals to pregnant adolescents and mothers, and transportation for mothers and children, the total annual cost would be roughly $1,600.

Question No. 12

The Assistant Secretary for Health said at the hearings of the Select Committee on Population last March that the proposed initiative will reach only 20 percent of the adolescents in need. When do you intend to expand this program to reach the remaining 80 percent of those at risk and in need? (If this isn't planned,) What other initiatives are being considered?

Answer

Expansion efforts, of course, depend on how successful the current initiative, including the project grant program, is in reducing pregnancies and the negative consequences associated with early childbearing. We would not want rapid expansion only to discover that a high proportion of our programs were neither effective or efficient — having sufficient funding to serve all teenagers in need is not equivalent to having quality programs which truly meet the needs of this population. Moreover, through

the adolescent pregnancy initiative, and especially the project grant program, we expect to get a multiplier effect by demonstrating what kinds of programs work best and by heightening public awareness of the adolescent pregnancy problem. Some States, localities and private groups already contribute to pregnancy prevention efforts and services for pregnant teenagers and young parents. We expect that a federal example will stimulate increased support.

Question No. 13

One area of concern is the problem of parental consent for contraceptive services for minors. What is the department's feeling about this? What will be the regulations regarding parental consent and confidentiality in the implementation of this proposal?

Answer

Most of the States (between 30 and 40) already permit adolescents to obtain medically prescribed contraceptive services without parental consent. In addition, a recent Supreme Court decision struck down a statute which denied teenagers access to non-medical contraceptives on the grounds of interference with individual liberty. Thus, the constitutionality of the remaining statutes which restrict the access of adolescents to contraception is open to question. In implementing the law through regulations, HEW will encourage State and community leaders to review all of their State's laws bearing on the adolescent pregnancy problem, including parental consent and confidentiality to ensure that they address effectively the problems of adolescent pregnancy. At the same time, we will encourage contraceptive service providers to be sensitive to the desirability of family involvement.

Question No. 14

Under this bill, an agency must provide a "core of services" to qualify for a grant. The bill does not, however, specify a basic set of services. Should there be such a set? If so, what should this set include?

Answer

We do not believe that there is a specific set of core services that should be required to qualify for a grant. Since we are hoping, through this program, to learn what "works," we want communities to have the maximum flexibility possible in developing their approaches to the problems of adolescent pregnancy. However, we do expect most communities to link together or directly provide services such as family planning, pre-natal health care, education and counseling.

Question No. 15

What are the standards you plan to use to evaluate the success of the program, particularly with regard to the training and skills of personnel involved with delivering services. What are the evaluation criteria that will be used in determining the effectiveness of the program?

Answer

While we have not completed a detailed evaluation design, it will include three components progressing simultaneously —

> First, a project will report on progress against certain management objectives, for example, the numbers and types of adolescents served, the proportion of teens in the community receiving primary prevention services, trends in access to services, number of referrals to other agencies and proportion receiving services, etc.
>
> Second, projects will report on, and be evaluated locally against, a few selected national outcome objectives, for example, number of initial or repeat pregnancies among those served, changes in health status of those served, number remaining in or returning to school, number of adolescents who keep their babies who are on welfare after one year, etc. This type of evaluation would be both through reporting by local projects and local evaluations by an objective third party.

Third, national evaluation of program impact and of what sort of projects work best and why. Impact evaluation would compare like communities with and without projects as to incidence of pregnancy, health status of adolescents and their babies, school dropout rates, number on welfare, etc. This will include a longitudinal study of program participants and non-participants. Evaluation of what works best would be by comparing certain projects with certain components (perhaps randomly added) against projects in similar communities without these components.

The evaluation design will be completed and ready to implement prior to the initiation of program funding.

Question No. 16

Legislative initiatives in family planning began with Title V of the Social Security Act and the Economic Opportunity Act of 1964. Since then, Federal commitment toward the direct provision of family planning services has grown in the establishment of the National Center for Family Planning Services and the enactment of the Family Planning and Population Research Act of 1970. The Health Services Amendments of 1978 greatly increases authorizations for appropriations for family planning services and research. The Report of the Committee on Interstate and Foreign Commerce states that these "increases have been included particularly to address the newly recognized need for adolescent services and for infertility research and services." There seems to be a duplication of effort on the part of this proposal. Please comment on the need for this extra $60 million appropriation on the part of Congress when other mechanisms and funding sources are in place.

Answer

First, existing HEW programs have a narrow legislatively defined focus. Maternal and Child Health services under title V of the Social Security Act are limited to health services for prospective mothers, children, and infants, and family planning services; Community Health Centers are restricted to providing health services in medically underserved areas; and title X projects concentrate on providing family planning services.

- The recent HEW assessment of Family Planning services to teenagers has given us an indication of how difficult it is for single purpose providers to establish a multiple services network. Even though many family planning providers expressed a need for both medical and non-medical referrals, under 20 percent of the providers had systematic referral networks. Most referrals were informal and non-systematic and were for pregnancy related health services.

Second, while we could modify existing authorities and program management, such as title X, each program would still have its own specially defined focus and the probability of multiple services and linkages would be enhanced only slightly.

- Funds would still go to those providers who have major target groups to serve, of which adolescent pregnancy is only one. They would still see themselves first as providers of a particular type of services, rather than of multiple services.

Third, new legislation will give local communities the freedom to choose the type of agency (or agencies) they want to have lead responsibility in developing an adolescent pregnancy prevention or care program.

- Some communities may decide that the school system should head up the program, other communities might use a YWCA, while some may ask a planned parenthood or family planning clinic to take the lead. The new legislation would provide local communities with the flexibility necessary to address the problem of adolescent pregnancy in a manner consistent with their priorities and needs.

Finally, for a number of reasons not fully understood, many sexually active adolescents will not go to providers of certain types of services.

- Many do not go to family planning clinics or to health clinics. These adolescents, many of whom probably never use contraception, and who contribute a disproportionate share of pregnancies, need to have alternative facilities.

Question No. 17

What do you envision as the staffing plan in HEW for this new adolescent program? Where will the program fit into the organizational structure of HEW?

Answer

Currently, we envision the new office as part of the Public Health Service and the Director reporting to the Assistant Secretary for Health. Operations will be coordinated with the Office of the Deputy Assistant Secretary for Population Affairs, the Office of Human Development Services, and the Office of Education and other Public Health Service Agencies.

We are working on a staffing plan, but it is still incomplete. We will be happy to furnish the committee with a staffing plan as soon as it is completed and approved by the Secretary.

Question No. 18

Coordination and establishing linkages will help urban areas that already have some level of existing services, but what about rural and suburban areas which lack any service components?

Answer

In rural and suburban areas which currently lack any of the service components outlined in the bill, grant money could be used to directly provide the services needed. The bill also gives the Secretary authority to waive the linkage/direct service allocation if he sees fit.

Question No. 19

Who will provide technical assistance and to whom?

Question No. 20

Why is training provided by institutions and consultants not included in this proposal?

Answer

We consider that the best providers of training currently available are the staff of the existing community multiple service projects addressing problems of adolescent pregnancy. We intend to fund successful projects to help train new projects in other communities, rather than fund expensive university training projects or consultants. We fund institutional training from other programs -- State and local training under title XX, Health Manpower, etc. -- and we will be encouraging training institutions to provide special training concerning adolescent pregnancy problems.

Question No. 21

How was the 50 percent services/50 percent coordination figure derived? What was the rationale behind this provision? Sec. 102(e)

Answer

We first made a policy choice that some funds should be used for linking existing services and some be available for new services, and to ensure this, we needed some restriction on the amount of money to be used for new services. The 50 percent figure derived from our understanding of the extent of service availability, the difficulty (and often prohibition against) using categorical funds for coordination between services with different legislative mandates, and the need to curtail the development of a separate service delivery system for adolescent pregnancy which would duplicate existing health, social service, and education delivery systems.

We believe that through linkages, projects will help adolescents get greater access to the services which are available in their local communities and increase the use of entitlement programs, such as Medicaid. The funds which are earmarked for improved linkages and coordination should have a multiplier effect in terms of local, State, and Federal resource utilization.

However, we recognize that in some communities, services are not currently available and will need to be provided through project grant funds. In such cases, the bill allows us to waive the limitation on funds for direct services.

Question No. 22

What criteria do you envision being used in granting a waiver of the limitations specified in Sec. 102(a)?

Answer

We envision that the criteria for waving the 50 percent limitation will include at least the following factors:

- the extent to which prevention and pregnancy-related services are available;
- the incidence of low-income families in relation to the types and costs of services available; and
- accessibility to services which may be available, e.g., rural vs. urban differences.

Question No. 23

Is it feasible to redistribute HEW's budget to allow greater emphasis on infant, day and drop-in care services for adolescent parents?

Answer

We believe that day care services for adolescent parents are an important factor in allowing young parents to return to school. There are several means by which day care services can be provided, including co-operative arrangements among a number of parents, school-based centers, and family day care arrangements. The HEW budget currently provides several hundred million dollars in Title XX day care, some of which can and is being used for day care.

Question No. 24

How many teenagers can be reached by providing $30 million in services?

Answer

We can not say precisely how many teen-agers will receive services through this legislation. There are several reasons for this:

- We do not know what the allocation of resources will be between prevention and support service projects, nor the separate services to be provided in each project. Since the estimated average cost for these two types of programs is very different — a range of $50-110 per client for prevention, and an average of about $750 for support programs (if medical, education, and day care services would be provided directly through the project grant program costs, of course, would be higher) — the number of clients served will depend on the emphasis chosen by the local programs and the cost of the various configuration of services which will differ from community to community.
- Additionally, the major objective of the linkage concept is to provide adolescent access to services for which they are eligible, but currently are not receiving. For example, a project may work with a comprehensive health center to sensitize CHC staff to the particular problems of adolescents and the need for the provision of counseling, information, and contraceptives to the teen population served by the clinic. They then may utilize CHC staff to directly provide these services.

32-704 O - 78 - 4

- Projects must also utilize to the fullest extent possible existing entitlement programs such as Medicaid -- title XIX, and general service programs such as title XX. Therefore, a project through its linkages with other community agencies would ensure that Medicaid-eligible pregnant adolescents receive adequate pre-natal health care -- but the project itself would not pay for the health care directly. Or a project may work out an agreement with the agency administering title XX so that school age mothers are given priority in the provision of day care services.

- Thus, substantial numbers of adolescents will be served as a result of the linkages established.

- Also, with the waiver provision -- we are not necessarily limited to $30 million for services.

Question No. 25

How much money do you feel will be necessary in Fiscal Year 1980 and Fiscal Year 1981?

Answer

The Department is now in the process of developing our fiscal year 1980 budget proposals which will then be reviewed by the Office of Management and Budget and subsequently recommendations made to the President. Because the FY 1980 and 1981 budget decisions have not yet been made, we are requesting a three-year authorization in the proposed legislation at a "such sums as may be necessary" funding level.

Question No. 26

How much will the Federal grant decrease in each succeeding year after the second operational year of the project under Section 103(c)(2) of H.R. 12146?

Answer

After the second year of funding, the award for a project must be decreased by at least 10 percent of the amount of the previous award. We have found that after programs are operating fully there is often the opportunity to decrease the proportion of Federal grant funding because the project has begun to obtain some third party reimbursement for covered services, primarily Medicaid. The project has had time to develop other sources of support where that is available. Finally, after a year or two, most health service projects are able to provide services on an increasingly efficient basis so that the cost per person served actually decreases.

Some projects will have difficulty meeting this requirement. Many of the services provided will not be reimbursed by Medicaid, patient fees are difficult to obtain from low-income individuals and State and local governments are becoming increasingly selective about the programs they will support.

The waiver, allowed in Section 103(c)(3), will have to be used to permit projects to continue essential services while the 10 percent reduction in Federal grant funds is administered. The first reduction of 10 percent will probably apply to all projects with no reduction in services, but some projects, no doubt, will be unable to have Federal funds reduced an additional 10 percent without cutting some services. Many projects will have to receive a waiver of the third 10 percent cut or substantially reduce services. No project may be funded beyond five years so additional cuts are not discussed.

Question No. 27

What do you estimate to be the results to be achieved by this program? Please provide an impact study on this proposal with particular attention on the coordination mechanism this bill emphasizes and if existing services are able to handle the current caseload.

Answer

We believe that this program will help prevent unwanted pregnancies among adolescents and help adolescents who are pregnant or parents to remain healthy, stay in or return to school, learn how to properly care for their children, obtain necessary job skills and, in general, become more productive and independent citizens and family members.

We cannot state with any certainty the number of young people who will be helped by this program. This would depend among other variables on the division of funds between prevention projects and projects to serve teenagers who are pregnant or parents. If all of the funds were spent on the latter, we would be serving about 113,000 families. If all the money were spent on prevention programs, a larger number would be served, since such services are less intensive.

Question No. 28

What will happen to a grantee after the 5-year Federal funding terminates? What funding mechanism will take over once the Federal support ends?

Answer

We anticipate that once programs have been established and can demonstrate their effectiveness, they will be able to continue through a combination of private, state, and local funds and through support from existing HEW categorical programs. These programs and funding sources should be tied into each project from the time of initial funding and assume a greater share of the funding burden in each subsequent year.

We believe this gradual turn over of funding can be accomplished for two reasons:

- 0 Other funding sources are much more likely to be willing to fund a program with a proven track record; and
- 0 Much of the cost in establishing a network of services is related to the time and effort which it takes to develop the linkage mechanism. After a program has been operational for five years, costs in these areas should be minimal, since the nature of these costs will be for maintainance rather than development of linkages.

Question No. 29

Who will have responsibility for the coordination/linkage component of this proposal -- private facilities; local, state, or Federal government; or regional planning commissions?

Answer

The Office for this initiative will be established in the Office of the Assistant Secretary for Health with the Director reporting to the Assistant Secretary for Health. This office will be responsible for developing programs and for developing coordination/linkages.

Staff from this office and appropriate regional staff will work with communities to assist them in coordinating and linking services together. Both staff members and expert consultants will help to motivate communities, parents, and public and private non-profit groups, religious groups, federal agencies and others, in order that comprehensive services can be achieved.

Question

Will provision of family planning services through this new legislation erode Title X of the Public Health Service Act? Would the provision of similar services under this new legislation be a duplication of effort? (p.5)

Answer

This legislation is one part of our initiative package. We think it is important to stress that we have attempted to develop a cohesive, coordinated program to combat the problem of teenage pregnancy. The new legislation is not intended to replace, erode or duplicate Title X efforts. The primary focus of Title X

programs is to offer preventive services; under the Administration's proposed legislation, we intend that these services be strengthened. As you know, in addition to the legislation under discussion, the President's FY 79 budget requests a substantial expansion of family planning services for adolescents. First, we have expanded and retargeted Title X in FY 79 to provide for an additional $18 million for family planning services to an additional 240,000 adolescents. Second, the expansion of other programs will make additional family planning services available. The increases in the maternal and child health and community health centers will provide family planning services to an estimated 85,000 adolescents. With enactment of the expansion called for in our CHAP legislation, more than 200,000 additional adolescent females will be eligible for family planning services. We believe these expansions of existing legislative authorities will help to narrow the gap between adolescents at risk of pregnancy and those receiving family planning services.

We do not think that duplication of effort will result from enactment of the legislation. Where services already exist, the projects funded under the new legislation will be required to ensure that teenagers receive services from existing Title X grantees. Title X projects in many communities may actually become the primary grantees under the new legislation by providing service(s) directly and assuring coordinated provision of other health, social and educational services. However, it is also important to note that there are still areas in this country where no family planning services are currently funded. This legislation will enable us to fill in gaps and, where no preventive and comprehensive programs exist, funds appropriated under this legislation may be used to initiate these services.

The focus of the new legislation is on comprehensive services currently not available under the Title X authority. Rather than duplication of effort, we think we will be better able to meet the needs of adolescents in a more coordinated and strengthened way.

Question

The thought of a free floating office within HEW's organizational structive is of great concern to me. Who will be administering the project grant program, and to whom will this administrator be responsible. (p. 9)

Answer

See number 9.

The next section responds to questions that were raised by Representative Beilenson in his testimony before the Subcommittee. Page numbers refer to the page on which the question appeared.

Question

The first problem is that the proposed legislation fails to define any clear requirements for preventive services. Are preventive services limited to family planning, or are counseling and family life education included as well? (p. 4)

Answer

See response #1 to Rogers questions

Question

The Secretary stated that a "significant proportion" of the program budget will go for projects providing preventive services. What is a "significant proportion?" (p. 4)

Answer

See number 2.

Question

Family life and sex education should be one of the major lines of the prevention of unwanted pregnancies and births. Unfortunately, it has not been given important emphasis in the Administration's bill. (p. 5)

Answer

We believe that education is an important component of a prevention strategy, and the bill reflects this belief. We do not know, however, what kind of educational efforts are appropriate for particular young people.

Major gaps exist in what we know about adolescent pregnancy in relationship to (1) what schools and other are now doing in education concerning sexuality, responsibility, and pertenting, including the number, type and quality of education programs and who they serve; (2) how effective these efforts are; and (3) what sort of education works well and why. We simply don't know if education by itself really prevents adolescent pregnancy. A portion of the money which we have budgeted for education needs, develop and disseminate materials and provide assistance, as well as study present and past education approaches to improve upon successful methods.

To date the role of the federal government has been limited in the area of education about sexuality and responsibility. But there have been some small scale efforts and we are expanding these.

- Since January 1972, the Special Programs staff of the Bureau of Elementary and Secondary Education has provided technical assistance, information and field coordination for adolescent pregnancy and parenting programs.

- Since 1972, the Children's Bureau of the Office of Child Development, in cooperation with the Office of Education, has been operating an Education for Parenthood program. Most grantees combine class work with direct experience with children. Students in these programs often work with children at day care or Head Start centers, kindergarten camps, or hospitals.

- NIE is planning a $1 million research effort on how schools deal with pregnant adolescents and on education factors and their relationships to childbearing, analysis of family life and sex education curricula, and research on what kinds of education improve life changes of pregnant adolescents.

- CDC will examine current sex education approaches and develop techniques for evaluating their impact, support demonstration programs, assist States and local governments, and develop and disseminate tapes and materials to health and education organizations.

In addition to these, some of the $60 million of the project grant program will be used for education at the community level. These funds give communities the opportunity to develop educational materials and approaches appropriate to their locale and to integrate it with their multiple services approach.

Question

If this new program in the prevention of unintended pregnancies desires to be innovative and effect change perhaps one new approach might be an emphasis on the sexuality and responsibility of the adolescent male. (Rep. Beilenson's testimony, p. 7)

Answer

See Rogers Q 4

Question

There is much reference in this bill to "comprehensive services" but the Administration never defines what is meant by this. What do comprehensive services include? Will programs be required to deliver all of the defined comprehensive services in order to be eligible for funds? (p. 7)

Answer

See Rogers Q. 5

Question

What do you mean by linking services? And what services need to be linked in order for a program to be eligible for funds? (p. 7)

Answer

By linking services we mean the development of systems, such as case management, whereby programs can insure that each adolescent is provided the appropriate services, based on his or her needs. The actual services may be provided at a single site setting or through referral and follow-up to other providers within a defined service network.

There are three crucial aspects to such a system:

- There has to be close coordination between the providers whose services are to be linked: providers have to know who offers what kinds of service, what the eligibility requirements are for each service, and what is the availability of these services.
- Projects must have an organized internal tracking system which ensures that teens are not only referred to appropriate services, but that these referrals are also followed-up.
- Training must be provided to project staff, so that they have the capacity to identify the needs of individual teens and the information to make the necessary referrals.

The multiple services to be linked will include those services which communities determine will best serve their adolescents. To do this, we have given communities maximum flexibility in their selection of the number and kinds of services to be linked. We do expect, however, that most projects will include family planning, health care, education and counseling services.

Question

Since the amount of funding is so low...what does HEW plan to do with the limited money available? Will it be spend to coordinate existing services within a community, or to establish and provide basic services in communities where they do not now exist? $60 million is simply not meaningful when discussing the kinds of problems I think this bill is designed to alleviate. (p.8)

Answer

First, $60 million for a new program and an increase of $148 million for the first year of the initiative are not insignificant amounts on money, especially when coupled with our proposed expansion and improvement of the Medicaid Child Health Assessment program. For example, we expect to expand health services coverage to approximately 280,000 additional adolescent females through expansion of Medicaid. Community Health Centers, Maternal and Child Health and title X programs will also provide family planning and health services to an additional 470,000 adolescents.

Second, during the coming fiscal year, we will be evaluating the effectiveness of various components of the adolescent pregnancy initiative, especially the new project grant program, to identify the need for, and administrative capability to itilize effectively, more funds.

Question

HEW must indicate to Congress its intentions for future commitment to this program. Does the Secretary see this as a program which will continue for an indefinite period of time with substantial future increases in funding? Or will the act continue to receive only the low level of funding requested for this fiscal year? (p. 9)

Answer

We believe that the prevention of adolescent pregnancy and the provision of support services to pregnant adolescents and school age parents is one of the Department's -- indeed the President's — highest priorities. In fact, in a time of budget constraints, we believe that creation of a new program at a $60 million an authorization level is an extremely significant administration commitment.

However, budget level decisions for the remaining years of the legislation can not be adequately made until we have some evidence of the effectiveness of the program -- that is, we need to know how well our grantees are performing, what the remaining unmet needs are, and the availability and capacity of additional grantees to meet these needs. Therefore, we will take careful look at our evaluation to ensure that the program is contributing to the effective and efficient prevention of adolescent pregnancy and the provision of support to pregnant adolescents. If more funds are necessary and can be used effectively, we will not hesitate to ask for them.

Mr. ROGERS. Are there any other questions at this time?

If not, Mr. Secretary, thank you for being present.

The committee will stand in recess for 30 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order please. We are continuing our hearings on the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

Our next witness is R. Sargent Shriver. We are very honored to have you before the committee, Mr. Shriver. I know Mrs. Shriver is here. We will be pleased to have her join you at the table.

Also, Dr. Janet Hardy, who is Professor of Pediatrics at Johns Hopkins and Robert Montaque, executive director of the Kennedy Foundation. We welcome you all to the committee.

We are delighted to have you here. We know of the strong interest you have in this legislation. Your statement will be made a part of the record in full. You may proceed as you desire.

STATEMENT OF R. SARGENT SHRIVER, WASHINGTON, D.C., ACCOMPANIED BY MRS. R. SARGENT SHRIVER; AND JANET HARDY, M.D., PROFESSOR OF PEDIATRICS, JOHNS HOPKINS SCHOOL OF MEDICINE AND DIRECTOR OF THE JOHNS HOPKINS CENTER FOR SCHOOL-AGE MOTHERS AND THEIR INFANTS

Mr. SHRIVER. Thank you very much, Mr. Chairman, and Congressman Carter. We are all very pleased to be here and to take this opportunity to commend the committee itself and the members of it for your enterprise in having the hearings on teenage pregnancy.

In fact, until the Senate and the House took an interest in this there was not a great deal of national attention being focused on it. Sure, there were some stories in the papers but there was not serious, long-term interest shown. We believe that your interest and attention to the problem will be very helpful.

I would like to read a part of my testimony but not all of it [see p. 57]. Then, between the three of us we would like to try to answer questions that you might have.

To begin it might be well to emphasize that although we hear the phrase a great deal that there is "an epidemic of teenage pregnancy," it really is not an accurate phrase. I am not an epidemiologist obviously or a public health doctor, but it has been explained to me that in medicine, an epidemic is a particular type of situation in which a spontaneous action occurs or a new development occurs causing a rapid increase in a particular disease. Then the situtation should and can be dealt with as in a measles epidemic or malaria epidemic.

But teenage pregnancy is not that kind of situation. Experts use a different word, "endemic." By that, the doctors mean, as I understand it, that you have a situation where there is a steady, constant problem, and, to a certain extent, its causation is societal or familial. Moreover, it does not change a great deal over the years.

In addition despite the use of the word "epidemic," the the rates, the actual rates of teenage pregnancy, have remained relatively constant over the last 10 years. What has happened is that there

are more children proportionately being born to teenagers now because older women are having fewer children.

So, that the statistic which was, let us say, 3.8 percent 10 years ago for teenage pregnancies compared to total pregnancies, is now up to 8 percent. That increase is not because you have more teenage pregnancy. On the contrary, the situation is steady for teenage pregnancy. It is an endemic situation, not an epidemic situation.

I think it is important to emphasize this reality because unless we know precisely the situation we are dealing with we cannot get the right remedy for it. That is what we are looking for, all of us, an effective remedy.

Now, many people say that the way to deal with the teenage pregnancy phenomenon is through what they call "primary prevention." A number of scientists have studied this idea in depth. One of the most outstanding of these authorities is Dr. Jekel from Yale University. According to these experts who have studied teenage pregnancy in the greatest depth, "it is unlikely," to quote them, "that a massive increase in family planning or sex education or even in abortions would have a substantial effect today on teenage pregnancy."

There are complicated reasons for this reality. The most that any of the experts believe that primary prevention could affect by so-called primary prevention might be 10 percent of the teenage pregnancies. I am not talking now about the pregnancy of older women. I am talking about a teenage slice of the population, especially those 17 years of age and younger.

Even within the teenage population it is the tendency of the people who have been working on the problem in it the longest, to deemphasize the 18-year-old woman or the 19-year old woman and to talk about the ones who are 17 and down as being the ones who most need attention at this time.

They get the least attention, and with them, I might add, the evidence again is that primary prevention is least effective.

There are some places like the city of New Haven where there has been a comprehensive effort made to provide all kinds of family planning; there are outreach workers in public housing projects; there are family planning clinics all over the city. Yet this all-out effort has not had an appreciable effect on the number of pregnancies of teenagers of 17 years of age downward. I mean downward in age.

I would suggest that if you have not had a lot of testimony on this important point it might be well for you to address questions in writing to people like Dr. Jekel. Another very eminent expert is Dr. Lorraine Klerman whose husband has just been made head of the Mental Health Division by the Secretary of HEW and another is Dr. Lorevan, a great expert in the Department of Education and Health at Yale University.

They could give you the scientific evidence about this better than I can. I know from having talked to them that they will be very happy to do that.

At the same time that scientific evidence indicates there is not a great deal that can be achieved with the younger teenage population by "primary prevention." We do have evidence that significant

progress can be made by what we call "comprehensive teenage programs." The best one that I know about or, the one I know the most about, is the one by Johns Hopkins University, the one being run by Dr. Janet Hardy.

It is not just a medical program. Consequently, on page three of my testimony I describe it as a process. I ask the question: What is the nature of this process? How can it be started? How can it be sustained? What will it cost?

I would like to say the process is a social process. It involves health professionals, educators, social workers, parents, community leaders, ministers, and so on, the entire community.

Experience has shown that these local people are the ones capable of developing ways to help adolescents to understand and appreciate their responsibilities as members of the community and as future parents. The interest of the parents and preservation of community values as well as a proper regard for individual autonomy are maintained and safeguarded in this Maryland program in much the same way that the successful Head Start program involves parents and community leaders in the education and development of children.

The "Head Start" approach, or the Maryland process, does not rely on individualistic action alone but deals with human beings as part of a family and of a community, thus strengthening all three at one time; that is, the individual, the family and the community.

It is a program of social-medical action. It changes and helps and improves the entire social fabric within which these teenagers live and where the pregnancies occur. By dealing with the total human situation, the process of prevention builds a better foundation for responsible sexual life in the future.

Now, what has happened at Johns Hopkins is detailed on pages 4 and 5 of my testimony. By developing a sense of responsibility in the adolescent toward themselves and their babies and toward the community, by providing family planning and family life education in a manner which respects the total life and humanity of individuals involved, not just their sex lives, progress has been achieved.

Enabling the participants to cope with all their problems, pursing a holistic approach so that you work with them on their education, their work, their love, their sharing, you achieve extraordinary results.

The effect with respect to second and third pregnancies is extremely good. Such pregnancies are greatly reduced. It is hard to say which particular element produces that great reduction but the fact is that the reductions are achieved.

The same thing is true with what they call "the ripple effect." This "ripple effect" prevents pregnancies in the first instance because what happens is that if a young woman is participating in this program, in a little while her friends who are not pregnant start coming and participating, even as auditors. They begin to learn about their responsibilities, self-control, alternatives to pregnancy, et cetera.

The community gets energized so that actual reduction in first pregnancies takes place. So, by establishing a relationship which is one based on trust and confidence and continuing it over a period

of years you begin to change the matrix of the society which encourages the early pregnancies.

Now, there are about 11 components in the Johns Hopkins program. I am just going to recite the titles, not the details although they are all specified in my testimony.

Early and prenatal care are essential. Social services are essential. Comprehensive health care for the infant is essential. Long-term, follow-up services for a minimum of 2 years is essential. Education is essential. Adequate day care is essential. Ways to bring the fathers in as much as possible are essential.

The Hopkins program has had considerable success in getting fathers to come in, not 100 percent obviously, but considerable.

Involving the community as a whole; training the staff; providing transportation, and then an evaluation component are essential. What has been discovered, in a practical way, is that if you do all of these things you achieve beneficial, practical results.

On page 12, I say a little bit about the cost because, as the Secretary said, everybody is concerned about rising costs of Government, and I think that the facts ought to be detailed here. The Hopkins program, based on 2 or 3 years of operation, indicates that the cost for the mothers over 2½ years is $507.

It is $148 for the baby over 2 years, and it is $45 for the fathers over 2½ years, or a total cost of $700 for the program over 2½ years.

If you appreciate that the $60 million proposal in the program has to be augmented by local contributions which would raise the total to $85 million, and if you spread that $85 million over this number of children, you will see that this program, this new initiative by the Government could supply services, comprehensive services to 117,000 families, or a total of 351,000 teenage mothers, their babies, and the fathers.

Thus, the average cost per person drops down to $242. On pages 12A and 12B of my testimony there is a complete itemization of all these figures.

In the conclusion of my testimony I try to emphasize, as you can see, Mr. Chairman, that this is not a one-shot type program. It is long term; it is comprehensive; it does not rely on individualistic action.

It relies on total social-medical action. Two, it is not a warmed over version of a program which works with older women. These younger women, and especially the communities from which they come, are special problems; and they really need special programs with specially motivated and specially trained people.

The third thing is that it is not just a simple sex education program. One of the realities we face in this effort is that a lot of these young women are turned off by school, or they in fact are already out of school. The place where normally you would expect sex education to be given, let us say in the school, does not reach these youngsters at all—I will not say all of them but most of them.

Many of them are disassociated from their parents; they are disassociated from all kinds of community resources. So, in the way some think of sex education as being helpful, to a middle class child, it does not work with these children.

The Hopkins "Headstart" style program is not a hand-out program. It is not a business of just continually providing something to somebody forever. The idea is to build up the young woman's own ego, to give her a sense of her own self-importance, to give her a sense that she can control her own life through work, through school, through discipline, through self-control, in fact to make her independent of the program so that she can become an organized, if you will, person in control of her own destiny.

I should like to introduce into the record a letter which was written by Dr. Jekel of Yale University to Senator Harrison Williams on the Senate side in which he tells about why this kind of program works, based on his knowledge of this program and also on his experience in New Haven. [See p. 74.]

I should like also to introduce into the record a letter from the mayor of Baltimore, Mayor Schaefer, who commends this program to your attention, Mr. Chairman. [See p. 77.]

Mr. ROGERS. Without objection, they will be received for the record.

Mr. SHRIVER. And I should like to submit a third letter from the director of the Department of Social Services of the city of Baltimore, Kalman R. Hettleman, who is responsible for all the welfare programs in the city of Baltimore.

From the public point of view, both the mayor and this man, Mr. Hettleman, see the public effect of this Hopkins program in terms of what impact it is having on the cost of welfare, what value it is to them as public officials at the local level, whether it does or does not in fact produce results.

These letters, I think, are the most compelling evidence from public officials that I have seen in support of any precise program deadline with teenage pregnancy.

Mr. ROGERS. Without objection, they will be received. [See p. 79.]

Mr. SHRIVER. Let me just conclude my remarks, if I may, by saying this: Many times we Americans like to get easy solutions to complicated problems, especially if the solution is quick and cheap and somebody else has to do it. In fact, teenage pregnancy is a complicated societal and familial problem which has been with mankind forever, which is accentuated by bad conditions of one type or another, frequently associated with poverty and which cannot be cured by a sort of silver bullet type of approach.

I think that we as a society and particularly the Congress as representative of national Government should make a commitment, understanding that it is going to be a long-term commitment, but that it is going to be cost effective and not settle for what looks like a facile inexpensive solution. There is no facile solution.

Thank you very much.

[Testimony resumes on p. 81:]

[Mr. Shriver's prepared statement and attachments follow:]

STATEMENT OF HON. SARGENT SHRIVER

I am pleased to appear before this Subcommittee to testify in support of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

The Members of this Subcommittee deserve credit for focusing the attention of the nation on teenage pregnancy. Until you and your colleagues in the Senate took an interest, this important problem received little attention. There was no organized lobby concerned with it, no federal funding to meet the needs. Even today there is little coordinated effort for teenage mothers, for their babies, or for the fathers of these babies. Your attention to this problem is therefore timely, needed and welcome.

Despite many popular magazine stories, there is no epidemic of teenage pregnancy. Those who have described the existing situation as an epidemic have led many to believe that teenage pregnancy is a condition like malaria or measles which can be treated successfully with pills or vaccines or various contraceptive devices. In America we seem to search for "one-stop" solutions to problems -- in this case, a "magic bullet" which will put an end to teenage pregnancies before they begin. But in the case of teenage pregnancy, so-called primary prevention efforts in practice are not likely to prevent many of the pregnancies now occuring among teenagers. This fact has been amply explained by James F. Jekel, M.D., M.P.H., Associate Professor of Public Health

in the Yale School of Medicine. I am happy to submit for the record here in the House a letter on this subject which was sent by Dr. Jekel to Senator Williams, Chairman of the Senate Committee now considering this proposed legislation. Dr. Jekel is probably the nation's foremost scientific expert on teenage pregnancy. He has published more than 20 scholarly papers on the subject and last year was the recipient of the national prize bestowed by the National Alliance Concerned With School Age Parents.

Rather than an epidemic manageable like measles, we face today in teenage pregnancy an endemic situation. It is part of the societal and family situation in many places, not just an individualistic occurence. It will not be eliminated by more and better sex education; more and better contraceptives; more and better abortions; or by less sex and violence on television. These panaceas are attractive because they are cheap, quick, and aimed right at the biological, anatomical target. Unfortunately, the endemic teenage pregnancy situation is not, paradoxically enough, primarily a biological problem. Sure, pregnancy is a biological event; but the problem is not pregnancy. It's the social, psychological, economic, moral situation which cause these girls to accept, even to want, pregnancy despite their extreme youth. Until we face up to that fact we cannot begin to develop a program or process to reduce, let alone eliminate, early teenage pregnancy.

In the last few years, a great deal of thought and work has gone into ways of dealing with this endemic situation. We know that about 600,000 teenagers, one-third of them 17 years old or younger, are giving birth to babies which on the average are far less healthy and have lower expectations of success in life than other babies. We know that comprehensive teenage pregnancy programs run by health and other professionals who care about teenagers and their babies can change the endemic conditions. We know that these programs produce results, that the results are cost effective, and socially desireable. We know that many of the fathers as well as the mothers can be rescued and redirected. We know that community as well as personal values can be upgraded. But we also know that this process requires time, work, discipline, community effort, and adequate financing.

What is the nature of this process? How can it be started? How sustained? What will it cost? What results can be hopefully anticipated?

The program about which I know the most and where the most measureable results and cost figures are available is the program in Baltimore, Maryland operated by Johns Hopkins School of Medicine. That program is in effect a social-medical process -- a social-medical process conducted within and through a comprehensive, long-term, systematic program containing eleven components. It is a social process, not just a health or education or vocational endeavor because it involves health professionals, educators, social workers,

parents, community leaders, ministers. In short, the entire community. Experience has shown that these local people are the ones capable of developing ways to help adolescents to understand and appreciate their responsibilities as members of the community and as future parents. The interests of parents and preservation of community values, as well as proper regard for individual autonomy, are maintained and safeguarded in this Maryland program much in the way the successful "Headstart" program involves parents and community leaders in the education and development of children.

The "Headstart" approach or process does not rely on individualistic action alone but deals with human beings as parts of a family and of a community, thus strengthening all three at one time -- the individual, the family and the community. The Hopkins program follows the same philosophy. Its program of "social-medical action" helps the entire social fabric within which teenage pregnancies occur, initially or repetitively. And by dealing with the total human situation, this process of prevention builds a better foundation for responsible sexual life in the future.

Experience to date indicates that comprehensive adolescent pregnancy programs partaking of this social-medical or "Headstart" approach do reduce repeat pregnancies significantly by:

(a) Developing a sense of responsibility in adolescent parents towards themselves, their baby and their community.

(b) Providing family planning and family life information in a manner which respects the total life and humanity of the individuals involved, not just their sex life.

(c) Giving the adolescent participants more understanding and appreciation of universal moral values.

(d) Enabling the participants to cope with all their problems -- work, love, sharing, etc..

Moreover, comprehensive adolescent pregnancy programs have also been shown to reduce too-early pregnancies through the so-called "ripple effect". This results when participants in adolescent pregnancy programs influence their brothers and sisters, friends and schoolmates.

In those cases where too-early pregnancies do occur, a comprehensive program of early detection becomes important. Early detection and referral to necessary services can be achieved by:

(a) Outreach workers from the program maintaining contact with schools, housing projects, hospitals, public health clinics, mental health centers, and neighborhood health centers.

(b) Public education including discussions, lectures, TV/newspaper articles aimed at the local community and special groups, e.g., churches, teenage clubs, etc..

32-704 O - 78 - 5

(c) Good coordination, accessibility and cooperation within the human services network in the community. This results in more effective referral mechanisms.

(d) Removal of barriers to the provision and reception of care. Adolescents need to be able to give consent for their own care, and care should not be denied because of inability to pay or because of ineligibility for medical assistance, etc..

This is a condensed description of the social-medical process pioneered by the Johns Hopkins Center, but to understand better how the specific results are achieved it would be useful to itemize other essential component parts of this teenage pregnancy program. Of course, it will certainly not be possible at the outset for every adolescent pregnancy program to provide every service already existing at Hopkins; but no program, I submit, should be funded unless its grant application contains a plan by which the program would achieve, within the grant period, the level of comprehensive care and prevention which has proven to be essential.

In the Hopkins program we can distinguish the following eleven components: --

1. Early and Continuing Prenatal Care

This should include:

(a) Early detection of pregnancy (see below)

(b) Comprehensive health care. Because of the high incidence of complications, e.g., prematurity, the following should be included:

- Thorough medical evaluation and observation of the pregnancy.
- Screening, diagnosis and treatment of prenatal and postnatal conditions. For the mother this should include medical, socio-emotional, educational-vocational care; for the child this should include physical, developmental and socio-emotional care.
- Special referral to clinics for particular medical problems of diabetics, nervous disorders, etc.
- Special nutritional support by provision of food supplements for both mothers and infants, e.g., through WIC.
- Health related education which would include:
  - + Management of pregnancy, i.e., physiology of pregnancy and reproduction.
  - + Self-care, including nutrition and risk factors related to drugs, cigarettes, alcohol, etc.
  - + Responsibility of parents.
  - + Parenting, including infant care and child development.

2. Social Services

The social services component of successful programs deals with the numerous problems of support (e.g., financial and emotional), continued education, and liaison with other community services and agencies. This involves working not only with the mothers but with the fathers, and with their families in order to assist the young parents to develop a plan leading to self-sufficiency and independence.

These services are oriented toward helping adolescents cope with their particular situation and deal with it in such a way as to enhance their own self-confidence, self-respect and sense of responsibility to themselves, their baby and others in the community.

3. Comprehensive Health Care For The Infant

(a) Neonatal intensive care (if necessary)

(b) Periodic medical examination and screening, e.g., EPSDT

(c) Immunization.

(d) Evaluation and care by parent or parents.

(e) Diagnosis and screening of such problems as nutritional deficiencies, visual and hearing defects, mental retardation, learning disabilities, crippling and handicapping conditions and child neglect/abuse. Appropriate referral to specialized services should be made when necessary, e.g., to heart disease clinics.

4. Long Term Follow-Up Services for a Minimum of Two Years

This is an indispensable component because its duration and quality directly influence the physical and psychological health of the infant and its parents. These follow-up services should include:

(a) Comprehensive health care for mother.

(b) Parenting education.

(c) Counseling for parents and family members.

(d) Family planning and family life education.

(e) Integration of other services described below in an effective manner.

5. Education

Adolescent pregnancy programs must put special focus on education and make it possible and attractive for the young parents to stay in and complete their schooling. The education component should include:

(a) Access to an educational program, e.g., regular school program, vocational programs, G.E.D. preparation, etc..

(b) Parenting instruction.

(c) Instruction in child care and child development.

(d) Development of an understanding of community life.

6. Adequate Day Care

Adolescents should have access to day care centers, family day care, or child development programs which include the mothers and fathers themselves.

7. Ways For Including Fathers

Experience to date shows that involving fathers is important not only in raising their sense of parental and sexual responsibility but also in helping the mothers cope and the babies develop normally. It has been possible in many adolescent pregnancy programs to involve fathers meaningfully in:

(a) The mother's preparation for childbirth.

(b) The delivery room itself.

(c) Parenting instruction.

(d) Day care activities as a volunteer.

(e) Vocational education and training.

(f) Family planning and family life education and services.

8. Involvement of Supportive Community

Many adolescent mothers and fathers are isolated and often socially alienated from their community. An adolescent pregnancy program should seek to link adolescent parents to a supportive community by providing:

(a) Advocacy services for child and parents.

(b) Housing. Adequate housing is vital to the health and quality of life of parents and infant. This requires good liaison between the program and local housing authorities and social services agencies.

(c) Assistance from private and public agencies and organizations including churches, voluntary organizations and professional groups.

(d) Residential care, when appropriate, for pregnant adolescents.

(e) Adoption services when desired.

9. Staff Training and Education.

The responsibilities of an adolescent pregnancy program must include staff development at all levels. Staff members who can serve as role models contribute greatly. Employment of men on the staff and as program directors has proven useful in this regard.

10. Transportation

Adequate transportation resources should be available to adolescent pregnancy programs wherever needed. This is particularly important in rural areas where the need for adolescent pregnancy services is particularly acute.

11. Evaluation

A systematic evaluation is essential to determine success or failure in terms of numbers served, outcomes (perinatal death, low birth weight, damaged infants, repeat pregnancy, school dropout, chronic welfare support, etc.).

COSTS

One thing that seems to have been missing in much of the discussion I have heard about the proposals in this teenage pregnancy bill has been an estimate of the number of individuals -- teenagers and their babies -- that would be helped by $60 million of federal funds during the first year. I would like to attempt to give you such an estimate based upon the program at the "Johns Hopkins Center For School-Age Mothers and Their Infants."

That Center estimates costs (over and above delivery costs which are paid by the hospital, or by the families, or by Medicaid) as follows:

For mothers - $507 over two and a half years
For babies - $148 over two years
For fathers - $ 45 over two and a half years
Total - $700

Since H.R. 12146 requires communities to provide at least 30 percent of program costs, a federal allocation of $60 million would produce at least $85 million for programs. This $85 million would provide comprehensive, long-term services to over 117,000 families or to a total of 351,000 teenagers and their babies. Thus, the average cost per person served amounts to $242 (approx.) -- and this provides assistance on the average for more than two years.

A detailed cost analysis follows.

12a.

Type of Service	$ Cost of Service for Mother	Baby	Father
Pregnancy Diagnosis	$ 94		
Routine Medical Care	(Not an additional cost)		
Supportive Medical Services			
Medical - Prenatal	53		
Labor and Delivery - Medical Supervision and On-Call Nurses	36		
Postpartum - On-Call Nurses and Pediatric Nurse Practitioner	35		
Postpartum Visit - On-Call Nurses and Pediatric Nurse Practitioner		8	
Medical Follow-up		36	
Family Planning Supervision	6		
Medical Family Planning Service and Supplies	50		8
Educational Services (Obstetric Phase)			
Health Education - Prenatal and Postnatal	51		
Nutrition Counseling	8		
Vocational/Educational Counseling	12		
(Follow-up Phase)			
Education - Health, Nutrition, Parenting, Child Care, Family Planning, etc.	24	--	8

12b.

Type of Service	$ Cost of Service		
	Mother	Baby	Father
Education/vocational counseling	9	--	4
Social Services (Obstetric Phase)	30		
(Follow-up Phase)		17	
Psychological Testing			
Screening		14	
Assessment		22	
Community Outreach (Obstetric Phase)	23		
(Follow-up Phase)	8	8	8
Program Administration	31	26	8
Training and Consultation	12	4	2
Maintenance and Overhead	10	3	2
Evaluation	25	10	5
	$507	$148	$45
	TOTAL	$700	

CONCLUSION

The comprehensive program recommended by the Bill which I have described in greater detail is:

1. Not a one-shot program. We have learned that one-shot prevention programs will not work. As Dr. James Jekel of Yale University has shown, many young men and women, for complex social, cultural or psychological reasons will not take precautions even when contraception is available.

2. Not a warmed-over version of a program designed for older women. We have learned that programs designed for older women (as most prevention programs are) will not work for teenagers. These teenage girls have vastly different problems than most older women who become pregnant. They are disenchanted with what they see around them. They distrust the advice of older people, often including their parents. They are often drop-outs from school; without marketable skills; without jobs; unmarried; with a multitude of problems not concerned with their pregnancy. These young parents need specialized approaches; specially trained and motivated people who can help them; specially designed programs to give them support they can depend on, and values they can believe in.

3. Not a simple sex education program. We have learned that sex education programs in the schools will not work to reduce the number of pregnancies among these adolescents. As Dr. Robert Coles says, these young people are alienated from all our institutions and especially the schools. Many have already dropped out. When they become pregnant or have their babies they are very often not welcome back into schools. And so the schools cannot provide the anchor of trust or the moral authority which these young people need.
4. Not a handout. Instead it is a preventive health program that will result in future cost savings many times greater than the cost of the program.

This Hopkins program is an example of what physicians call preventive medicine. When a physician follows the goals of preventive medicine, he strives to bring the patient to a situation where the patient does not require the physician. The model for preventive medicine is not a child's relationship to a parent, a relationship of helpless dependency. Rather, the model for preventive medicine is the dependency of a husband and wife, or the dependency of teacher and student in its deeper sense (in Aristotle's sense of people sharing a common ideal). Trying to build

a better humanity for these teenage girls and their children requires the physician to develop the teenager who is dependent. The physician seeks to instill a sense of personal worth and self-sufficiency, and especially a sense of responsibility for themselves, so the young women do not feel embarrassed, but feel able, through their own efforts, and with community encouragement, to ameliorate their own problems.

The program which I have described encourages teenagers through their own efforts to take control of themselves and their lives. And the program works.

Consequently, I hope and trust you will promptly approve H.R. 12146.

Yale University New Haven, Connecticut 06510

SCHOOL OF MEDICINE
Department of Epidemiology and Public Health
Health Policy Project
60 College Street

June 19, 1978

Senator Harrison A. Williams
Chairman, Senate Committee on Human Resources
4230 DSOB
Washington, D.C. 20510

Dear Senator Williams:

My name is James Jekel, and I am writing comments on the draft of the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978. I am a physician with certification by the American Board of Preventive Medicine. I have been teaching at Yale University for 11 years and am currently Associate Professor of Public Health. During this time my main area of research has been in the area of school age pregnancy and programs for adolescents who have become pregnant. I am an author of a monograph and more than 20 papers concerned with adolescent pregnancy and comprehensive programs to serve them. I have also worked as a member of the board of directors of the Young Mothers Program in New Haven, Ct., and the National Alliance Concerned with School Age Parents.

I am encouraged at the recent evidence of concern on the part of Congress for an issue that has been of concern to many of us for more than a decade, but I am worried that the bill, in its draft form, is not sufficiently focused and does not guarantee an adequate emphasis on the care for pregnancies which do occur and are brought to term.

To start, I am concerned with the implication that all teenagers are adolescents (sec. 2(a)(2) says there were 600,000 adolescents who carried their babies to term. Over half of the 600,000 were deliveries to 18 and 19 year olds, many of whom were married.) I believe the bill should more clearly focus on those under age 18.

I am also disturbed about the bill's assumption that we can prevent many more teenage pregnancies than we are now doing. The evidence for this is weak, and is mostly based on surveys which suggest that many of the currently delivered young teenage pregnancies were unwanted. The belief that most, even many, of the first pregnancies now occurring to young adolescents are unwanted is, to my judgment, incorrect. Motivation is so complex that one cannot obtain reliable responses by interviews. Most likely the motivation was mixed, with some feelings for and some against pregnancy. However, mixed motives are usually sufficient to preclude the taking of preventive action. Most inner city teenagers I have heard, white and black, have stated that they wanted to have someone to love (i.e., the

baby) and someone to love them, and someone to give the kinds of things they don't think they had. The responses to interviewers are of dubious validity, to my mind, both because the young people may not know their real motivation, because motivation changes with time, and because they may give answers they think would be most appropriate. Moreover, many young teenagers would not take a specific preventive approach, such as the pill or an IUD, because to do that would be to admit to themselves they planned to be immoral by their standards. In the moment of love or pressure from young men, whom they like, however, spontaneity does not seem to have the same negative connotations that a "planned" prevention would mean to them. Thus, their understanding of and belief in moral behavior may actually hinder effective prevention. I also have serious medical concerns about giving young teenagers either the pill or the IUD, and I know of no other contraceptives that would have comparable use-effectiveness.

I certainly am in favor of increasing the availability of contraceptive services to a reasonable level, but there are already existing Federal efforts in this direction, which may be expanded further by other bills currently submitted. Putting still more money from this bill into contraceptive services for all sexually active teenagers would create duplication between programs and would diminish the resources available for those who decide to carry the pregnancies to term, and for the primary prevention of future pregnancies among this high risk group. I have detailed my serious concerns about ignoring "secondary prevention" in a recent paper published in the Journal of School Health; this paper is attached as "Appendix A" to this written statement. My special concern for the prevention of the rapid second child to teenagers comes in part from our own studies; a paper explaining my concern is attached as "Appendix B."

Implicit in the primary prevention approach is the assumption that many of the young adolescents who deliver would readily make use of contraceptives if they were only available, or would do so with a minimum amount of public information and "education." The former view is not supported by the New Haven experience, where after the 1965 Supreme Court decision, contraceptives became readily available and are now offered through a variety of sources, including a special Health Dept. clinic in a housing project, Planned Parenthood clinics, hospital clinics, and neighborhood health centers, in addition to private physicians. The rate of first young pregnancies remains high, even in the population of a strong neighborhood health center that offers every pregnancy prevention service.

The latter view, that "education" would lead to effective use of prevention, goes against the generally disappointing results of community-based behavior modification efforts. I would, however, support a series of community-based primary prevention efforts using a variety of methods on a demonstration basis, if careful evaluative research were included in each. There simply is too little known to state how best to achieve "primary prevention" in adolescents.

I am pleased with the emphasis in the current bill on improving, strengthening, and building on existing programs rather than substituting for local funding. The idea of improving "linkages" is a good one, but if the mechanism is not carefully defined in the bill, the development of regulations, and their subsequent administration, could become a nightmare and be seriously delayed. In my judgment, the best approach to the administration would be to turn the responsibility over to the states, after they have developed a state plan for adolescent pregnancy, showing the existing and potential statewide links between education, health, social services, and day care, etc. The states would then give money to the communities to use to build and link services in their own areas. I have seen this general approach work well in Connecticut (see Appendix C, which is a report of a State of Connecticut program that was able to establish and improve many comprehensive adolescent pregnancy programs around the state by using a limited amount of money as leverage to draw out, link, and focus community money and efforts.) Moreover, other states have demonstrated how a State department with the will and some resources can be effective in establishing and linking services (Michigan and Oklahoma may be cited as states that are making progress in this regard.)

Another reason the States must be involved is that if project grant applications must come to the Federal level, the most successful grant applications will come from the strongest programs who already have the ability and the experience required for successful grantsmanship. Therefore, the monies would help the stronger programs rather than those in most need of help. State personnel are in a better position to judge local need and potential than is the Federal givernment, and are better able to monitor the progress and to provide technical assistance to local programs.

Also, the entire effort would need a high quality program of technical assistance to the States and to local efforts, which should be receiving support through this bill.

Two of the most important services are missing from the first draft of the bill: pregnancy testing and day care. Pregnancy testing is essential if the young mothers are to have early access to care. Day care is necessary if they are to receive the long term follow-up which is necessary to maintain the short term gains demonstrated by evaluative research.

Last, there is inadequate evaluation built into this bill. Unless money is specifically appropriated for a major evaluation effort (I would estimate this would take 2-3% of the appropriated money), at the end of 5 years Congress will not be sure that the program has accomplished its objectives.

I hope these comments are helpful. I would be willing to expand on these points or to address other issues. Please write or call (203) 436-4205.

Sincerely,

James F. Jekel, M.D., M.P.H.
Associate Professor of Public Health

JFJ:fw
encl.

WILLIAM DONALD SCHAEFER, Mayor
OFFICE OF THE MAYOR • CITY OF BALTIMORE
260 City Hall, Baltimore, Maryland 21202, (301) 396-3100

In reply refer to: MO 40

June 27, 1978

The Honorable Paul G. Rogers, Chairman
House Sub-Committee on Health
and Environment
2407 Rayburn House Office Building
Washington, D.C. 20510

Attention: Dr. George Hardy

Dear Chairman Rogers:

The City of Baltimore, under the impetus of the Mayor's Office, has launched a major planning effort toward a comprehensive approach to teenage pregnancy prevention including coordinated services to adolescent parents.

There is widespread recognition that adolescent pregnancy and parenthood have far reaching adverse effects on the parent, the child, and society. From today's epidemic of teenage pregnancy our cities of tomorrow will reap a whirlwind of abused and neglected children, welfare dependent parents, and unstable families.

There are really two population groups which must be addressed with equal seriousness--the sexually active adolescent who, as yet, has not conceived a child; and the adolescent who has already borne a child.

The Johns Hopkins Center for School Age Mothers and Their Infants located in Baltimore City is reknown as a maternal model for serving those adolescents who are pregnant or already have a child. Consistent with Hopkins' national leadership in applying medical resources to social problems, the Center for School Age Mothers has provided a mix of medical, educational, and social services which have proved to be phenomenally successful in dealing with adolescent pregnancy. Most significantly, their follow up studies have demonstrated that only 5% of the adolescents participating in their program became pregnant again within one year as opposed to the national average of 25%! Clearly this is a

America's Best BALTIMORE

32-704 O - 78 - 6

proven model which could serve as a national standard for preventing second pregnancies and helping young parents overcome the normally devastating effects of early parenthood.

Though obviously a success, the program only reaches a small portion of the population at risk.

While we have made a beginning with adolescent parents, we have hardly begun to develop models for primary prevention of adolescent pregnancy. The Mayor's Office has recently convened a task force representing all significant public and private agencies to develop a comprehensive primary prevention program. This model, currently in the development stages, is mounting new interdisciplinary initiatives in sex education, public awareness, motivation and attitude change, and access to a comprehensive network of health care and birth control services.

The City of Baltimore is deeply committed to reversing the trend of statistics on teenage prognancy and enthusiastically supports every Congressional initiative that will assist us in this effort.

Sincerely,

William Donald Schaefer

Mayor

CITY OF BALTIMORE
WILLIAM DONALD SCHAEFER, Mayor

DEPARTMENT OF SOCIAL SERVICES
KALMAN R. HETTLEMAN, Director
1500 Greenmount Avenue, Baltimore, Maryland 21202

June 28, 1978

The Honorable Paul G. Rogers, Chairman
Subcommittee on Health and the Environment
of the Committee on Interstate and
Foreign Commerce
Room 2051S
Rayburn House Office Building
Washington, D. C. 20515

Re: The Adolescent Health Services and Pregnancy Prevention Care Act of 1978

Dear Chairman Rogers:

We are writing in strong support of H.R. 12146. As the local welfare agency in the City of Baltimore, we are in a special position to express such support. We not only know -- as our colleagues across the country -- of the desperate need for this legislation. In the City of Baltimore, we can attest that the kind of programs it would provide will work; the funds it will provide can be effectively spent. We know this from our close experience and working relationship with the Johns Hopkins Center for Teenage Mothers and their Infants.

We urge the Subcommittee to consider carefully not what the Johns Hopkins Center has conceptualized but what it has achieved. Others have provided the Subcommittee with full details of its programs. We would only briefly state that it has proven to be a functioning model for the kind of comprehensive services that make a measurable difference in the lives of the young mothers and children it serves.

The measurable results have been astonishing. To cite but several examples: Low birth weight, which has long been associated with low I.Q.'s and other developmental disabilities, has been reduced from 16.8% to below 10%. Follow-up studies have shown that only 5% of the adolescents participating in the program became pregnant again within one year compared to the national average of 25%. Within 18 months only 15% of the adolescents became pregnant again. National statistics reveal that 70% of young mothers become pregnant within two years. Also while 90% of adolescent mothers in Baltimore generally drop out of school, only 15% of the girls in the Hopkins program dropped out; 85% remained in school, graduating and getting jobs.

Of course many of the target population of teenagers are AFDC recipients who are served by this agency. We know first-hand that the success of the Johns Hopkins Center is directly related to the comprehensive, specialized nature of the program: to the fact that the program is directed specifically to adolescents and their unique needs; the continuous service from the prenatal period to three years post-natal; the educational component which includes family planning, child care and development and parenting skills; and the close working relationship between the program and other community agencies, public and private, such as this agency.

It is only through this kind of comprehensive, community-based program that we will be able to reach out and work effectively with these young people. We need to take a holistic approach to adolescent parents, dealing with both young mothers and fathers and their families and developing supports for them within the community. Only then can we understand and relate programs to the life style and attitude factors which are so critical.

H.R. 12146 holds out the hope and promise that a network of programs such as the Johns Hopkins Center can be developed. Mayor William Donald Schaefer of the City of Baltimore has expressed to this Subcommittee the vital role that such programs can play in the totally integrated network of services that the City of Baltimore is planning. In this agency we have just initiated our own pilot Single Parent Service program. This program includes outreach to youth-at-risk, counseling, support services, financial assistance and linkages with other community agencies. These services are provided by a group of specially selected and trained staff. As this program is located within the Department of Social Services, we are able to reach many adolescents as they apply for Public Assistance. Often this is before they become pregnant.

There is of course rampant skepticism in the country about untried new government programs. But the programs under H.R. 12146 can work. They have worked -- as the Johns Hopkins Center has shown. However only through H.R. 12146 will these kinds of programs be able to reach the large population of mothers and children who are so seriously and precariously at risk.

We urge your support of H.R. 12146.

Sincerely,

Kalman R. Hettleman

Mr. ROGERS. Thank you, Mr. Shriver, for a very comprehensive and helpful statement. Do you desire to make a statement, Mrs. Shriver?

Mrs. SHRIVER. No, Mr. Chairman.

Mr. ROGERS. Dr. Hardy.

Dr. HARDY. You were kind enough to let me submit some written testimony in your hearings. I think that beyond that, I would simply like to say that I have worked in this program with these teenagers. It seems to me an extraordinarily rewarding experience because one can help them through education to have much better lives and to help them prevent subsequent pregnancies which really wreck their opportunity if they occur.

We have been very fortunate in having very few second pregnancies in our program. Where it has happened, the girls have tended to regard it as a disaster, and I think it is.

Thank you.

Mr. ROGERS. Thank you.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I want to compliment Mr. and Mrs. Shriver and Dr. Hardy on this presentation. I think it is by far the best we have had today. It is more meaningful to me because it has more to do with the underlying problems which are really involved in teenage pregnancy.

You speak of the need to upgrade personal values and to help redirect young mothers. I agree with this, and think that this should be the case wherever possible. I also think we need to consider the total situation of the community and involve local people in this effort.

You mention churches, clubs, and so on. I would like to include other activities, such as organized athletics and instruction in art and music. We need to keep our youngsters busy to compensate for the lack of family activities. I think more than likely it is the breakup of the family unit that has helped cause this problem. Children are failing to receive at home the values and beliefs that are best learned in the family unit. They are falling out from under parental influence and as a result, are vulnerable to the wrong kind of information.

I do believe that in this legislation we should include language about the personnel in private, nonprofit organizations. I am interested to see that such personnel are people of skill and good training. In many cases this has not been true. I am sure in your case it must be true because you have had very good results.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you, Dr. Carter.

Mr. Scheuer.

Mr. SCHEUER. Thank you, Mr. Chairman.

I am sorry that I missed Mr. Shriver's testimony. I note that on page 2 of your testimony, Mr. Shriver, you talk about the fact that teenage pregnancy is endemic. You are absolutely right. It is a societal problem that we are well aware of. You state that teenage pregnancy will not be eliminated by more and better sex education, more and better contraceptives, more and better abortions.

Well, pregnancy, of course, will not be eliminated by abortions. All of us share your moral abhorrence to the fact of abortions. But we did get a great deal of testimony in our select committee hearings on this subject from groups who were opposed to abortions, the right to life groups, who supported better sex education. They counseled us on the importance of the family life type of sex education. It was not just bumbling, but an attempt to instill in people some feeling of who they are, and their own dignity and essential self worth, as well as trying to give them more respect for themselves. It also attempts to convey some concept of the beauty of the sex act, and at what time in their lives and under what circumstances it is appropriate.

They felt that was important. They certainly felt that the proliferation of family planning services was important and would help. They emphasize in both of these the importance of providing education in natural methods, as well as services using the natural methods, among others. They emphasized that the information about how natural methods work and the actual services themselves were not available enough.

I think we had a consensus by the time we finished that there was an urgent need for more sex and family life type education which would include all the information that a woman would need in order to engage in natural family planning.

It is a far more sophisticated activity than most other methods of contraception. It requires far more self discipline. It requires a far more goal oriented personality. It requires great self esteem and it requires a lot of knowledge about the physiology of the female human body in order to compute when the woman is in her fertile period and when she is in her infertile period.

These right-to-life witnesses, a number of them, were really, as I recall, quite unanimous that this kind of family life education, including knowledge about the females' fertility function, was essential. They agreed that the natural method should be offered not only from the point of view of information and education, but from the point of view of counseling in a service role.

I do not get that signal from your statements. I would be curious as to how you react to a fair number of witnesses who represented the right-to-life position.

Mr. SHRIVER. First of all, I am one who represents that position myself.

Mr. SCHEUER. You do indeed.

Mr. SHRIVER. In fact, when I was running the OEO I think I was the first government official in the Federal Government to inaugurate any kind of family planning under the auspices of the Federal Government.

So, I associate myself with that position. But that position, although useful for many people, is not—I am trying to indicate to you—apparently useful for these people. The people who are 11 years old up to 16 or 17 do not change their habits or their practice as a result of this type of education.

That does not mean it is not good. Don't misunderstand me. It is useful for most people perhaps but this is a special clientele, if you will, or special group at special risk. And with this clientele it is not especially effective. When the type of thing you are talking

about, and which those people support, has been tried on a rather intensive scale, for example, in the city of New Haven, it did not affect substantially the rate of pregnancy among these youngsters.

So, I am not contesting what you have just said nor am I contesting what they have testified to. I am only pointing out that it does not work, nor has it worked up until now with these youngsters. Now, both the mayor of Baltimore and Dr. Jekel up in Yale, who is intimately knowledgeable about the experiences in New Haven, say explicitly that it might be well worth while to try an experiment some place and see whether something different along those lines would in fact be effective with this clientele.

I am not opposing that. That would be like an experimental thing. But we do not have, according to scholars, any example of a case, a town, or part of a town where that kind of approach has been successful in reducing either first or second pregnancies among this clientele. On the other hand, the comprehensive program of which that is part—don't forget that—the comprehensive program like the Hopkins program of which that is a part—that kind of program does stop the secondary pregnancy and has a beneficial effect with respect to the first pregnancy.

Let me emphasize that again, in the total program we are talking about, Congressman, the comprehensive program family planning or parenting is in there together with the effect to develop self-esteem, jobs, et cetera. But with this clientele you cannot just go out and do that in 30 seconds, or merely with sex education no matter what type.

Dr. Hardy can tell you more about that by far than I can. She can tell you that better than I can. The reality is that if you have the young women in the program for 2 years and you work with them in the area you are talking about as well as many other things with respect to their job, education, and so on, then you can modify the behavior.

But the scientist will tell you—I think it is true; it has been proven—that as of now there is nothing in the literature that will indicate that a massive effort focused on family planning, let us say, will produce results with this population.

Mr. SCHEUER. That is news to me. I think we will have to look into it. Pregnancy is a biological, social, psychological, and economic event. You say "It is the social, psychological, economic, and moral situation which causes these girls to accept, even to want, pregnancy despite their tremendous youth."

Thus, we have three problems with teenage pregnancy that may be found on the bottom three or four lines of page 2.

Mr. SHRIVER. Yes, I know.

Mr. SCHEUER. The unmarrieds in the 11 to 18 age group provide us with three challenges. It is important to try to give them a sense of who and what they are, where their lives are headed, and how a pregnancy, at an early stage in their teens, will devastate their chances for a normal life, education, job, and happy marriage.

An obvious solution would be to have the teenagers defer sexual activity until a more appropriate time in their lives. It could teach them to want to use contraceptives, to give them enough sense of self-worth so that if they decide not to become sexually active, they at least, will not become teenage mothers.

Furthermore, they should be taught the mechanics of birth control. Some of them will choose the natural method; others will choose the barrier methods; others will choose chemical methods.

It seems to me that not all of these girls are willing and totally acquiescent in accepting pregnancy as either a necessary component to that sexual activity or a purely acceptable result of sexual activity.

There must be some, it seems to me, whom we cannot convince that this is an inappropriate time in their life to be sexually active but whom we might be able to convince that they at least should take the steps necessary to defer pregnancy.

Pregnancy at that time surely would have devastating effects on their growth and development and the realization of their own growth.

Mr. ROGERS. Dr. Hardy who runs the program at Johns Hopkins might give us some comment on that.

Dr. HARDY. I think Mr. Scheuer is correct. There are some girls who can be persuaded to defer sex. There are other girls who cannot be persuaded but who can be persuaded to use contraceptives. There is a third group of girls who will neither defer sex nor use contraceptives. Unfortunately, it is a rather large group when one considers the 17 years and under group.

Mr. SCHEUER. In the United States how many young women are 17 years and under, who will wilfully engage in sexual activity without the use of contraceptives?

Dr. HARDY. I think it is probably close to half. In taking the country as a whole, taking the population of girls with whom we deal in the inner city, 75 percent black group, it is larger than that.

But I would like to make a point about the contraceptives. You bring up the natural method. These are reasonably good for the girls who are 17, 18, and 19. But for the young teenager who is just passing through the early stages of womanhood, they tend to be very unreliable because the period tends to be unpredictable. They do not have regular cycles of ovulation.

I think that Dr. Kantner and Belnick in their studies have found a high percentage of the sexually active girls who say that they use these methods but become pregnant. There is very real need for research in contraceptions in young teenagers. There just is not good information about which method is the best, how to get them used regularly and so on.

The girls have a kind of psychological hangup about using contraceptives. They feel that they are doing something that is immoral; they are commiting themselves to an immoral act, whereas if sex just happens sort of spontaneously, without preparation, it is more acceptable to them.

It takes a good bit of education to get over that hangup.

Mr. SCHEUER. You are saying that education makes it possible for them to get over their hangup?

Dr. HARDY. We have a small percentage, 5 percent now, who do get pregnant again in 1 year.

Mr. SCHEUER. But most of them do not.

Dr. HARDY. Most of them do not.

Mr. SCHEUER. Sex education can either help defer sexual activity or promote contraceptive use.

Dr. HARDY. I think you need to provide the education. That is a vitally important thing to do.

Mr. SCHEUER. That is what I am getting at.

Dr. HARDY. I think you need to provide the contraceptive services also.

Mr. SCHEUER. That is all I am getting at.

Dr. HARDY. I have one further point. That is that these services, to be acceptable and effective, have to be provided in a kind of wholistic approach, as Mr. Shriver describes it.

Mr. SHRIVER. In other words, to go back and say it all over again, if you do primary prevention by itself, what these people say is that with this population it will not work. That is oversimplified but that is what they say.

Second, they say that if you do it just the way you describe it, Congressman, within a total program, then it is effective. What we are arguing for is not against what you said but in favor of the total program because it is in that setting that the results are achieved.

Mr. SCHEUER. How much would it cost for a young lady annually?

Mr. SHRIVER. It comes to $242 for the total. For the woman by herself it comes to $505. For the baby, $125 or $135; the exact figure is in the testimony; for the father, when they can get the father involved, it is $75. I think it comes to $700 flat or $750.

Mr. SCHEUER. I think that is appropriate for a target group consisting of young girls who have already been pregnant to prevent the second pregnancy.

But how about the young woman who has never been pregnant? How do we help her? Can simple family life type sex education plus the availability of services reach a significant number of that group?

Dr. HARDY. May I make a comment about that.

Mr. SCHEUER. Let us say in the setting of a simple neighborhood family planning clinic.

Dr. HARDY. When we ask the girls who come to our center why they did not use contraceptives, we find that they knew contraceptives were available, most of them even knew where they were available, but they did not get them.

Mr. SCHEUER. Did they tell you why?

Dr. HARDY. Yes.

Mr. SCHEUER. Why?

Dr. HARDY. Well, I am not clear why, partly because many of them do not want to use them. Undoubtedly, better education in the schools would help but that is going to be a long drawn out process. Research would help. We would know how to do it; primary prevention education is better but that too will take time.

Mr. SCHEUER. Of course, you see the ones who get pregnant. It is perfectly clear they were not contracepting. Maybe a good many young ladies and their cohorts, and I apologize for using that word, 12 to 16 years old who are not contracepting and do not become pregnant and you do not tend to run across them.

Dr. HARDY. As far as my information goes, the girls under 17 tend to make up a rather small proportion of the clients at family planning clinics. I judge from that that the family planning clinics have not been reaching this population. They reach some but not a large part of them.

Mr. SHRIVER. Mr. Chairman, may I just read two paragraphs from a letter which was introduced into the record here from Professor Jekel of the School of Public Health at Yale.

It is in the Senate record too. He is talking about the possibility of getting good results through primary prevention methods with this population. This is what he says:

> Implicit in the primary prevention approach is the assumption that many of the young adolescents who deliver would readily make use of contraceptives if they were only available or would do so with a minimum amount of public information and "education."
>
> The former view is not supported by the New Haven experience, where after the 1965 Supreme Court decision, contraceptives became readily available and are now offered through a variety of sources, including a special Health Department clinic in a housing project, Planned Parenthood clinics, hospital clinics, and neighborhood health centers, in addition to private physicians.
>
> The rate of first young pregnancies remains high, even in the population of a strong neighborhood health center that offers every pregnancy prevention service.
>
> The latter view, that "education" would lead to effective use of prevention, goes against the generally disappointing results of community based behavior modification efforts. I would, however, support a series of community-based primary prevention efforts using a variety of methods on a demonstration basis, if careful evaluative research were included in each. There simply is too little known to state how best to achieve "primary prevention" in adolescents.

That quotation summarizes what I was trying to say earlier, that what we have factually is this: We have reasonable proof that a comprehensive program of the type that Hopkins exemplifies actually works. We have a need probably to experiment with other forms, using maybe primary prevention to see whether that will work somewhere, but on the basis of current knowledge there is not any program of primary prevention that works with these youngsters.

Consequently, it is my hope that if the Congress approves this legislation that, since so little money is involved, there is not very much, that the major part of it by far, if not all of it, will be put into the programs we know will work.

And they work too, Congressman, not just in reducing the second or third pregnancy but they also have a beneficial effect on first pregnancy through what they call the ripple effect. In other words, once the girl who is pregnant becomes involved, her friends and others come in and they are beneficially effected.

I am not saying that is the crucial thing but it does have a preventive effect. It is a mistake to think that the comprehensive Hopkins approach is not preventive; it is preventive.

Mr. SCHEUER. It is not aimed primarily at the young girl who is sexually active and has not had a pregnancy yet.

Mr. SHRIVER. It is not aimed primarily—I did not say it was. It has a spill-over effect on her. What I am saying is that the programs which are aimed primarily at that girl have not succeeded.

Mr. SCHEUER. Therefore, we do not aim anything at that group?

Mr. SHRIVER. Not at all. Dr. Jekel said that he would "support a community-based primary prevention effort using a variety of

methods on a demonstration basis if carefully evaluative research were included in each."

Now, Baltimore is trying to do that right now. They are trying to come up with a model, if you will, an experimental model, focused on primary prevention that would work. I am not against that. All I am saying is that we do not have the model that works. However, we do have a model that works in this other way—the Hopkins way—and, since there is not much money available under this title, my recommendation from a practical point of view would be to put our money where you know it will produce the most results.

Mr. SCHEUER. I think all of us are in favor of targeting in on this special clientele of teenage girls who have an unwanted, out-of-wedlock pregnancy.

Mr. SHRIVER. That is where the rub comes. If they were all unwanted, it would be a different game.

Mr. SCHEUER. I appreciate Mr. Shriver's testimony, and I want to say for the record, that we had a great deal of evidence that family planning programs do work for teenagers. I will submit a statement at this point for the record, Mr. Chairman——

Mr. ROGERS. That will be fine.

Mr. SCHEUER [continuing]. Outlining some of the testimony we had and some of the studies indicating that we can reach many, if not most, of those young girls who are sexually active and who have not had a pregnancy yet.

Mr. ROGERS. As I understand it, the family planning is a part of what you propose.

Mr. SHRIVER. That is right.

Mr. ROGERS. Their proposal is a more comprehensive program.

Mr. SCHEUER. It is an excellent and a needed program. Aimed at the young person who has become pregnant, they recommend demonstration programs aimed at the young girl who has not become pregnant—they recommend research and demonstration programs.

It is my understanding, and I will submit a brief statement for the record, that there are programs that have reached sexually active teenage girls and have averted conception. There are a lot of sexually active teenage girls in this country who use contraceptives and do not become pregnant.

Mr. ROGERS. Thank you.

[Testimony resumes on p. 102]

[The following material was received for the record]:

Supplementary Statement of

The Honorable James H. Scheuer

August 10, 1978

In his written statement before our Subcommittee on Health and the Environment, Sargent Shriver observed that "in the case of teenage pregnancy, so-called primary prevention efforts in practice are not likely to prevent many of the pregnancies now occurring among teenagers." While I wholeheartedly agree that primary prevention programs will never totally eliminate the problem of unwanted adolescent pregnancies, I do think that Sargent Shriver has underestimated the usefulness of primary prevention efforts such as the provision of contraceptive services for sexually active adolescents. Since this issue continues to re-appear in the various hearings on adolescent pregnancy before the House and the Senate, I would like to take this opportunity to explore in more depth some of the myths and misunderstandings about the effectiveness of and the need for family planning services for sexually active teenagers.

During hearings of the Select Committee on Population and in other Congressional forums, some witnesses have suggested or asserted that contraceptive information and services "don't work for teenagers" and that elected officials should turn toward other, vaguely specified programs of prevention or support. Yet, while the proportion of young women age 15-19 who are sexually active increased substantially between 1971 and 1976, pregnancy rates in this age group remained constant. This can only be explained by increased use of effective contraceptive methods among those teens who are sexually active. If contraception for teenagers had not "worked" and they had become pregnant at the same rate as in 1971, there would have been 1.29 million pregnancies among 15-19 years olds or about 19% or 203,000 more than are estimated to have actually occurred.

Similarly, researchers at Johns Hopkins University have calculated that current use of birth control among unmarried teenagers prevents an estimated 680,000 premarital pregnancies per year. That is, if none of today's sexually-active young people were using birth control the annual number of such pregnancies would be 1,460,000, instead of the 780,000 that actually occur.[1] Nevertheless, the argument that "contraception doesn't work for adolescents" has been made, both directly and indirectly, to the Select Committee on Population, as well as to the Interstate and Foreign Commerce Subcommittee on Health and the Environment, the House Select Education

Subcommittee, and the Senate Committee on Human Resources. The most frequently recurring themes were the following:

1. Teenagers won't use contraception even when it's offered and available.

Several witnesses have argued that because of ambivalent feelings, inadequate motivation, unwillingness to admit that they are sexually active or reluctance to prepare for sexual activity, adolescents do not enroll in family planning programs. "We are not at a stage where we can say this kind of program works," the Senate Human Resources Committee was told in mid-July. By 1976, however, 1.15 million adolescent women were enrolled in family planning clinics, more than a threefold increase since 1971 when 396,000 teenagers obtained services from family planning clinics.[2] Furthermore, it is estimated that an additional 1.2 - 1.3 million teenage women receive contraceptive services from private physicians.[3] These patient statistics are corroborated by the John Hopkins nation-wide studies of adolescent contraception and pregnancy which found that between 1971 and 1976 the proportion of sexually active unmarried teenagers using some form of contraception at last intercourse rose from 45 to 64 percent.[4]

It is important to remember, in this context, that only recently have attitudinal and legal barriers to contraception for adolescents begun to fall and that considerable obstacles still remain. As services have become more available, the evidence indicates that teenagers have enrolled in clinic programs and adopted effective contraception methods more

rapidly than did married adults in the 1960s.

2. Family planning is already easily available; other, more significant challenges related to teenage pregnancy deserve our resources and attention.

It has been suggested that we live in a contraceptive society, and that free access to family planning by all can be taken for granted. While it is true there have been impressive gains over the last decade in the delivery of family planning services to low income persons and teenagers, the fact remains that more than 1.6 million adolescents -- over two in five of those who are at risk of an unwanted pregnancy -- did not receive medically prescribed contraceptives in 1975, either from organized programs or from private physicians.[5]

Physicians in private practice may be unable or unwilling to meet the fertility control needs of sexually active teenagers, or teenagers may be hesitant to seek contraceptive services from private doctors. In any case, the 1976 Johns Hopkins study found that nearly half of all teenagers who had ever used the pill -- 44 percent of whites and 58 percent of blacks -- obtained their first prescription from a family planning clinic rather than a private doctor.[6] This pattern is unique in the U.S. health system, where fewer than one-fifth of Americans of reproductive age depend on clinics for general medical care.

In our health system, virtually no one goes to a clinic if alternative sources of care are available to them. Family planning clinics have emerged as the principal point of entry to medical contraception for sexually active teenagers.

The available evidence does not suggest that improvements in the delivery of contraceptive services to U.S. teenagers have occurred routinely, nor that the need for contraception is already met. Instead, it appears that family planning clinics and expanded, targeted support for adolescent services within those clinics are indispensable to any serious national effort to do something about teenage pregnancy.

3. Present contraceptive techniques and established family planning programs do not meet the special needs of adolescents.

As imperfect as existing contraceptives are, evidence from the 1976 Johns Hopkins study indicates that they have a significant impact on teenage pregnancy rates. By correlating data on contraceptive use with data on premarital pregnancies, the Johns Hopkins investigators found that the likelihood of becoming pregnant varies directly and consistently with the kind of contraceptive used and with the regularity of use.

- Most (52 percent of whites and 71 percent of blacks) of those sexually active teenage women who never use contraception become pregnant.

- Nearly one in four (23 percent of whites and 30 percent of blacks) of those who sometimes use contraception, either medical or nonmedical methods, become pregnant.

- One in six (16 percent of whites and 18 percent of blacks) of those who consistently use nonmedical methods become pregnant.

- Fewer than one in 16 (6 percent of whites and 5 percent of blacks) of those who consistently use medical means of contraception, oral contraceptives or the interuterative device, become pregnant.

Those who do not use contraception are three times as likely to become pregnant as those who use a nonmedical method, the authors noted, and ten times as likely to get pregnant as those who use a medical method. Among blacks, the disparity is even greater, with non-users almost fifteen times as likely to become pregnant as those who consistently use the most effective contraceptives.[7]

4. One shot preventive programs will not work.

In at least two hearings, the organized family planning network was characterized by one or more witnesses as a

32-704 O - 78 - 7

one-shot preventive program with services too limited to have any meaningful impact. The medical services available to a patient in the organized family planning network include a basic physical examination and medical history, health education and routine provision of VD and cancer tests, blood pressure screening, urinalysis and blood tests, as well as an assessment of the most appropriate means of contraception.

Teenagers, as a group, are healthy, and the assumption that most young women need more extensive treatment has not been substantiated.

There are exceptions to this pattern, of course, where intensive counseling and services are undoubtedly needed, as are ancillary services for drug abuse, alcoholism, psychiatric care, etc. But this involves a special and far more limited group of youngsters. The organized family planning program was established for a different purpose -- to provide effective means of contraception to those who want, but would not otherwise receive it.

In 1976, teenagers comprised about 28 percent of the patients served and 40 percent of the new patients in organized family planning clinics.[8] Among teenagers attending a family planning clinic for the first time, increased use of the more effective methods of contraception was striking, from 32 percent prior to clinic enrollment to more than 82 percent following enrollment.[9]

The significance of these statistics is underscored by evidence that young women starting with a medical method of contraception are substantially more likely to continue use than those who started with a non-medical method.[10] While it is clearly true that family planning programs do not meet the needs of certain adolescents, it seems equally clear that they have made noteworthy progress in delivering effective, medical means of contraception to many adolescents.

5. The availability of birth control leads to more teenage sexual activity.

Young persons today are initiating sexual activity at earlier ages and some witnesses suggested that this trend results from increased access to contraception (although other witnesses related the trend to phenomena as diverse as long-term changes in American family life, earlier onset of menstruation, new patterns of individual behavior and inappropriate programming by the mass media.)

Whatever the causes of earlier sexual experience and however disturbing this trend may seem to be, we know that the majority of teenagers who begin sex do so without using contraception, and few adopt it before they have been sexually active for several months. The 1976 data collected by the investigators from Johns Hopkins University found that six out of 10 teenagers failed to use either medical or nonmedical

means of contraception the first time they had intercourse. There was an average of 1.4 years between first intercourse and first contraception for those who initiated sex before age 15; an average delay of six months for those who began intercourse between 15 and 17.[11]

A study of contraceptive patients between the ages of 14 and 18 in Michigan indicates that eight out of 10 had been sexually active for one year or more before seeking clinic services.[12] An earlier study of 13-17 year olds attending family planning clinics for the first time in California found that virtually all were previously sexually active; most had been having intercourse for more than a year.[13]

The available research consistently indicates that access to contraception is not in itself a major factor in the initiation of sexual activity.

6. Increased contraception doesn't solve the problem; as clinics have handed out more and more pills, teenage pregnancy has gotten worse.

Mary Grace Kovar of DHEW's National Center for Health Statistics has reviewed data from the Division of Vital Statistics on birth rates among women under age 20 since 1966 (see Table 1). In spite of earlier initiation of sexual activity among teenagers between 1971 and 1976, she observed, teenage pregnancy rates have remained at about the same level

as before (due to increased use of contraception).

Recent information from the Johns Hopkins study adds weight to Ms. Kovar's data. As Table 2 indicates, the number of young women between the ages of 15 and 19 increased 8 percent between 1971 and 1976; the number who were sexually active increased much more rapidly -- by 33 percent. If other factors remained constant, one might expect pregnancies to have increased comparably with the increased number who were sexually active. As Table 3 indicates, however, the number of pregnancies increased much more slowly; the pregnancies per thousand sexually active adolescents declined by almost 14 percent.

Table 1. Birth rates of women under age 20, according to age and race of mother: United States, 1966-76

	Age		
	10-14 years	15-17 years	18-19 years
Total[1]	Live births per 1,000 women		
1966	0.8	35.7	120.3
67	0.9	35.3	116.7
68	1.0	35.1	113.5
69	1.0	35.7	112.4
70	1.2	38.8	114.7
71	1.1	38.3	105.6
72	1.2	39.2	97.3
73	1.3	38.9	91.8
74	1.2	37.7	89.3
75	1.3	36.6	85.7
76	1.2	34.6	81.3
White			
1966	0.3	26.6	108.2
67	0.3	25.7	104.0
68	0.4	25.6	100.5
69	0.4	26.4	99.2
70	0.5	29.2	101.5
71	0.5	28.6	92.4
72	0.5	29.4	84.5
73	0.6	29.5	79.6
74	0.6	29.0	77.7
75	0.6	28.3	74.4
76	0.6	26.7	70.7
Black			
1966	4.2	97.9	219.2
67	4.4	99.5	213.4
68	4.7	98.2	206.1
69	4.8	96.9	202.5
70	5.2	101.4	204.9
71	5.1	99.7	193.8
72	5.1	99.9	181.7
73	5.4	96.8	169.5
74	5.0	91.0	162.3
75	5.1	86.6	156.0
76	4.7	81.5	146.8

[1] Includes all other races not shown separately.

Source: Division of Vital Statistics, National Center for Health Statistics

Table 2. 15-19 Year Old Women, 1971 and 1976

	1971	1976	% Change
Women, Age 15-19	9,712,000	10,446,000	+8%
Sexually Active Women, Age 15 - 19	3,392,000	4,498,000	+33%

Table 3. Pregnancies to 15-19 Year Old Women, 1971 and 1976

	1971	1976	% Change
Pregnancies to 15 - 19 Years Olds*	959,000	1,069,000	+11%
Pregnancies/1000 Sexually Active Women, Age 15 - 19	283	238	-16%

* Including Conservative estimates of abortions to adolescents in 1971.

Table 4. Births to 15-19 Year Old Women, 1971 and 1976

	1971	1976	% Change
Live Births to 15 - 19 Year Olds	624,000	559,000	-10%
Births/1000 Sexually Active Women, Age 15 - 19	184.0	124.0	-33%

Table 5. Summary: Adolescent pregnancies and births, 1976, compared to those expected if sexually active teens had maintained 1971 birth and pregnancy rates

a. Sexually active women age 15-19, 1976	4,498,000	
	(1)	(2)
b. Pregnancies (1) and births (2) per 1000 sexually active women age 15-19, 1971	283	184
c. Expected 1976 pregnancies (1) and births (2) based on 1971 rates [a x b]	1,272,000	823,000
d. Pregnancies (1) and births (2) to women age 15-19, 1976	1,069,000	559,000
e. Difference	203,000 (or 19%)	264,000 (or 47%)

Sources (Tables 2-5):

Bureau of the Census, Current Population Reports, P-20, No. 306; P-20, No. 307; P-25, No. 643. Social and Economic Statistics Administration, U.S. Department of Commerce.

National Center for Health Statistics, unpublished data for 1976; Vital Statistics, 1971, Vol. 1, Natality. Tables 1-16, pp. 1-20.

M. Zelnik and J.F. Kantner, "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971," Family Planning Perspectives, 9:55, 1977.

E. Sullivan, C. Tietze and J.G. Dryfoos, "Legal Abortions in the United States, 1975-1976," Family Planning Perspectives, 9:3, 1976.

1. M. Zelnik and J.F. Kantner, "Contraceptive Patterns and Premarital Pregnancy Among Women Aged 15-19 in 1976," Family Planning Perspecitves, 10:135, 1978.

2. For patients served by organized family planning programs: Data from patient reporting systems; surveys of the Alan Guttmacher Institute, and projections of 1975 data from these sources performed by the Alan Guttmacher Institute. For age distribution of patients served by organized family planning programs: Data of the National Reporting System for Family Planning Services, 1976.

3. The Alan Guttmacher Institute, Contraceptive Services for Adolescents: United States, Each State and County, 1975, New York 1978.

4. M.Zelnik and J.F. Kantner, "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971, "Family Planning Perspecitves, Table 9, 9:55, 1977.

5. The Alan Guttmacher Institute, Contraceptive Services for Adolescents, op. cit.

6. M. Zelnik and J.F. Kantner, "Sexual and Contraceptive Experience...," Table 14.

7. M. Zelnik and J.F. Kantner, "Contraceptive Patterns and Premarital Pregnancy...," Tables 1 and 8.

8. The Alan Guttmacher Institute, Data and Analysis for 1977 Revision of DHEW Five-Year Plan for Family Planning Services, New York, 1977.

9. Ibid.

10. M. Zelnik and J.F. Kantner, "Contraceptive Patterns and Premarital Pregnancy..."

11. Ibid.

12. C.A. Akpom, K.L. Akpom and M. Davis, "Prior Sexual Behavior of teenagers attending Rap Sessions for the First Time,"Family Planning Perspectives, 8:203, 1976.

13. D.S.F. Settlage, S. Baroff and D. Cooper, "Sexual Experience of Younger Teenage Girls Seeking Contraceptive Assistance for the First Time, "Family Planning Perspectives, 5:223, 1973.

Mr. ROGERS. Is there a need for the different approaches, both in terms and education and direct services for the younger teens—say, 11 to 15—than for those 16 and older.

Dr. HARDY. There is a definition which includes the girls from 17 down from those who are 18 and 19.

Mr. ROGERS. Should we have a minimum range of required of core services for each of these centers?

Mr. SHRIVER. I think so. In my testimony I say so. I say that because we know that it works and, therefore, if the applied—

Mr. ROGERS. It would be well to say, "You should have these core services."

Mr. SHRIVER. I said within the grant period. Let us say they come in for a grant for 3 years; they should have a plan whereby at the end of the 3 years, those components that we have found through experience to be essential are going to be in that program. Then, if they cannot achieve that objective they should not get the money.

Dr. HARDY. May I make a comment there?

Mr. ROGERS. Certainly.

Dr. HARDY. I think one can make a list of the services which are essential and services which should be provided, but perhaps they should not all be provided by the program that is funded because they are already available through other programs in that community.

Mr. ROGERS. You might let us have some suggested language if you can.

Mr. SHRIVER. I agree with that. I did not mean you had to start all those things from scratch.

Mr. ROGERS. Mrs. Shriver, do you have a statement.

Mrs. SHRIVER. Not really. I think Sargent covered all of our thoughts adequately. I think Dr. Hardy did also. I do think, however, Congressman, that in this country we have to be careful that we do not end up encouraging teenagers to think that the sexual activity is good in itself.

Mr. SCHEUER. I agree with you. Let me clarify for the record. The first goal in reaching these kids and communicating with them would be to give them enough of a sense of self to induce them to defer sexual activity until a more appropriate time in their lives.

Mrs. SHRIVER. I will be very brief because I know how busy you are. I agree with that. I think that has been able to be done over at the Hopkins center. When you say to these girls, "If you nourish yourself well, you will have a healthy baby. Will you give up smoking pot?" They are willing to do it because they have a reason to do it. You are talking about a different kind of thing when you say these girls, and I talk a great deal to Dr. Coles, who tried to get down here today, in terms of making a lot of sex information accessible to a lot of girls who had not thought about this kind of activity and suddenly we become a country in which this becomes very easily available and even encouraged. Is that a good process?

Like you, I am concerned about sexually active girls. What Sargent is driving at is to emphasize that we have a lot of different elements in the picture. We have family values, community values, a lot of community agencies that want to help.

Maybe somehow, as they did so well in Head Start and other programs, there ought to be developed some way in which we have everybody involved in this rather than just saying, "Well, prevent it; we have the pill; you are sexually active; here is our prevention."

It seems to me there are other approaches and we can make other appeals to these girls in the final analysis. If you campaigned on television, "Get off drugs; you are going to be a mother someday," then go into a lot of other services, it seems to me if you could foresee the day when all the churches got together and talked about the ethical implications and responsibilities and labor unions participated—what I am trying to say, as Sargent points out, is that we have to take a comprehensive view.

We do not want all these girls pregnant; you are right. But have we thought it through? I would be delighted to read some of these experiences that we could duplicate across the country in which we can make the girls feel all the things you say they ought to feel.

I looked at some of the studies in Sweden where they give health education from zero and sex education too and they have not been able to attain any reduction in teenage pregnancy with that Swedish health and sex education.

That is a different country. I am not trying to make a direct comparison. But I do think somebody ought to give an awful lot of thought to how we are going to make the girls feel a sense of responsibility about themselves, responsibility about the community, "God, I am going to have babies. Who is going to pay for them?"

They have to come out and think that through but they are not going to get that kind of help or participate in that kind of thinking if they are told to get a pill and forget it.

Thank you very much.

Mr. ROGERS. Thank you.

That is well stated. I think we are basically in agreement. I see no aversion to expanding a comprehensive approach that has worked.

Thank you for your presentation. You are most kind to be here. We are grateful for your spending your time with us.

The committee stands adjourned.

[The following statements and letters were submitted for the record.]

STATE OF MARYLAND
MARVIN MANDEL
Governor
RICHARD A. BATTERTON
Secretary

GOVERNOR'S COMMISSION ON CHILDREN & YOUTH
1100 NORTH EUTAW STREET
BALTIMORE, MARYLAND 21201
(301) 383-3700

MRS. G. LUTHER WASHINGTON
Chairman
HENRI ANN DANIELS
Executive Director

TESTIMONY OF MARYLAND'S
GOVERNOR'S COMMISSION ON CHILDREN AND YOUTH
BEFORE
THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

JUNE 14, 1978

My name is Vivian E. Washington, and I am the Chairperson of Maryland's Governor's Commission on Children and Youth. I wish to thank the Subcommittee on Health and the Environment for giving me this opportunity to submit this written testimony.

Maryland's Governor's Commission on Children and Youth wishes to go on record as supporting HR 12146 - "Adolescent Health Services and Pregnancy Prevention and Care Act of 1978."

The Maryland Governor's Commission on Children and Youth was created by Executive Order in 1972 to act as an advocate for children and youth. The Commission is composed of 32 members including 10 youth representatives who are appointed directly by the Governor.

Since October, 1975, a sub-committee of the Commission has had as its focus School-Age Parents. In 1975 in the State of Maryland, there were 10,062 births out of wedlock. Of this number, 5,093 were born to mothers 19 years of age and under, and 2,740 were born to mothers 17 years of age and under.

In Maryland, the Commission working with the Maryland Congress of PTA, the March of Dimes, the Department of Education, and other concerned groups is working toward improving services on a comprehensive basis for adolescent parents. Emphasis has been placed upon education for parenting in the schools

as a way of helping young people become aware of the responsibilities of parenting before assuming this role at too early an age.

Comprehensive services to the adolescent parents are limited. In Baltimore City there exists the largest percentage of births to young parents. Baltimore City is fortunate to have programs at Johns Hopkins Hospital, the Laurence Paquin Junior/Senior High School and in the regular schools. In addition, several high schools have child development laboratories where it is possible for young parents to place their children. In spite of the existing programs there is a need for expanded services, and a great need for increased services to the young parent 16 years of age and under.

The passage of HR 12146 is imperative. Although resources exist in many Maryland communities and across the nation, better linkages would improve with the quality and quantity of program services to the adolescent parent population. The bill promotes innovative comprehensive and integrated approaches to the delivery of services and this is very important in the 16 and under year old teen-age parent population.

For the young woman 19 years of age and under, the knowledge and availability of contraceptives has not prevented un-wanted pregnancies. This is disucssed by Melvin Zelnik and John F. Kantner in their recent study published in the May-June, 1978 issue of Family Planning Perspectives. There is an inconsistent use of a birth control method by this high risk population. HR 12146 would make it possible for existing comprehensive programs to continue to study in depth and develop creative inno ative resources with an evaluative structure to produce effective ways of preventing and reducing pregnancies. in this high risk population.

As the Chairperson of the Maryland Governor's Commission on Children and Youth, I hope this Committee will give HR 12146 favorable consideration. The future of our country depends upon helping todays adolescents become productive independent contributors to family and community life.

Vivian E. Washington, Chairperson
Maryland Governor's Commission on Children
and Youth

VEW/jew

nacsap

National Alliance Concerned with School-Age Parents

7315 WISCONSIN AVENUE, SUITE 211-W
WASHINGTON, D.C. 20014

JANET BELL FORBUSH
EXECUTIVE DIRECTOR

TESTIMONY

of

JANET BELL FORBUSH

EXECUTIVE DIRECTOR, NATIONAL ALLIANCE CONCERNED WITH SCHOOL-AGE PARENTS

on

H.R. 12146

ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION
and CARE ACT OF 1978

before the

HOUSE SUBCOMMITTEE ON SELECT EDUCATION

July 24, 1978

I am Janet Bell Forbush, Executive Director of the National Alliance Concerned with School-Age Parents (NACSAP), a non-profit, multidisciplinary membership organization established in 1969 for the purpose of providing technical assistance to those who are working with pregnant adolescents, school-age parents, sexually active youth and their families. NACSAP's membership is comprised of nearly 2,000 educators, social workers, health care providers, youth workers, researchers and policy-makers from 47 states and the District of Columbia who are, for the most part, associated with state and community based service programs in urban and rural areas. Through its membership NACSAP is in contact with over 1,500 programs which offer an extensive though inconsistent array of support services to pregnant teenagers ranging from comprehensive approaches (including health, education, and social services) to beginning efforts which might only provide a single service.

NACSAP is greatly encouraged that this Administration recognizes the seriousness and complexity of the phenomena of adolescent sexuality, pregnancy and parenthood. Our organization is further encouraged that the Administration has introduced legislation which would assist states and communities in responding to families that need considerable help and understanding. As the only national organization devoted exclusively to the development of comprehensive programs and policies focusing both on the reduction in incidence of high-risk, unwanted pregnancies among teenagers and in the provision of essential support services for adolescents who carry pregnancies to term and become parents between the ages of 9 and 18, NACSAP is acutely aware of the critical need for this type of aid. It is, therefore, a pleasure for me to appear before the Subcommittee today in

general support of H.R. 12146. The observations included in my testimony are a reflection of the uniquely relevant experience of NACSAP's members and it is my intent, by expressing these views, to strengthen the measure and thereby assure the likelihood of it having maximum impact on this compelling problem after its passage.

The Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 is apparently intended to address three major concerns: 1) the need for general age-appropriate health services for adolescents; 2) primary pregnancy prevention services for teens; and 3) comprehensive treatment services for adolescents who are pregnant and/or have already had children. While all of these needs are important, on the basis of NACSAP's experience with those programs that are serving predominantly pregnant adolescents and young parents, it would be unrealistic to expect a $60 million dollar program to respond adequately to all of these areas. Therefore, since H.R. 12146 represents only one element of the Department of Health, Education, and Welfare's proposed Teenage Pregnancy Initiative and, in light of the Senate's recent passage of family planning legislation which includes funding for preventive services for adolescents, NACSAP recommends that the primary -- though not exclusive -- emphasis of this bill be on the needs of pregnant adolescents, young parents, their infants and extended families. To this end, NACSAP suggests that the title of the bill be rewritten to read: Adolescent Pregnancy and Parenthood Services Care Act of 1978. This would allow for the establishment of at least one modest categorical program directed toward adolescent parents and their families. It is this population which has been underserved or unserved in most communities and it is this group of families whose needs are so comprehensive as to be overwhelming. We view H.R. 12146 as a

beginning effort to meet the needs of this group of citizens and, if so focused, it would be a strong foundation upon which to build in successive years. NACSAP's concept of this as an on-going program is, of course predicated on what we believe to be the realistic assumption that regardless of the effectiveness of primary preventive strategies, there will continue to be some adolescents who bear children and who will therefore need comprehensive services to ensure the delivery of healthy babies and go on to realize their full life potential. In urging that the interpretation of H.R. 12146 be made on the basis of needs among adolescents who are already pregnant or young parents, NACSAP would nonetheless be supportive of an apportionments of the funds for primary prevention demonstration projects. For example, a split of 65-75% for treatment of the needs of those already pregnant or young parents versus 25-35% for primary prevention demonstration projects. Under any circumstance, NACSAP feels strongly that to achieve greatest results with the proposed $60 million program it will be necessary to allot funds to both existing and developing programs in all of the 10 DHEW regions. Without such a strategy, our experience would suggest that the established programs and agencies would be in a much favored position to apply for support.

Recognizing the continuing need for assistance to adolescent parents and their families, NACSAP recommends that the second and third years of this program be assured of authorizations of no less than $90 and $120 million respectively in order to provide existing programs with needed support to develop components not presently offered and to aid in the establishment of services in communities where support is not yet available. We are confident that if this element of the Teenage Pregnancy Initiative were to be funded at these levels, the current range of

32-704 O - 78 - 8

2 to 15% of pregnant adolescents and young parents who are in need of special consideration and who are currently served, at least in part, by existing agencies, would be substantially increased. (The estimated range of the client population now being served is derived from a 1977 NACSAP survey of 50 programs. More detailed reference to that survey is made in subsequent paragraphs.) I would, however, emphasize that the information available from school-age parent service providers is generally unsophisticated and lacks the precision of data available from standardized health and/or family planning information systems.

In addition to concern about the adequacy of the level of funding proposed in H.R. 12146, given its extremely broad focus, NACSAP takes issue with what appears to be a basic assumption underlying the measure which implies that services are, in fact, available to sexually active youth, pregnant adolescents and young parents but for some reason or reasons have not been linked together for the purpose of impacting on the issue of adolescent pregnancy. Based on a survey of 50 urban and rural community agencies which NACSAP conducted last year for the Joseph P. Kennedy, Jr. Foundation, it was found that the pattern of services is at best a "patchwork quilt" with very few comprehensive programs in place largely because essential services are either not available or are virtually inaccessible to those in need. The intent of this survey was to obtain information about the extent to which health, education, and social welfare agencies were responding to the needs of pregnant adolescents and young parents; to identify sources of financial support for services presently offered; and to identify gaps in those services. To carry out this project, NACSAP classified the agencies according to the variety and extent of services they offer and selected participating agencies on the basis of a stratified random sampling

technique. Class A agencies were those providing health, education, and social services to adolescents during pregnancy and for a clearly defined period postpartum. Class B agencies provide services in any two of the above categories and Class C agencies offer support in one of these areas only. Within the social services category, infant/child day care was included as a primary service requirement.

The basic data collection method for this survey was an extensive questionnaire followed up in 40 of the 50 communities by a site visit from NACSAP staff or a consultant. Anecdotal information was also obtained during the site visits to augment the standardized questionnaire. The findings of this survey along with the findings of a 13-state school-age parent needs assessment project conducted by NACSAP in 1975 would suggest that the assumption that basic services are already in place for young parents and need only to be linked or coordinated is misleading. While this is sometimes the case in large urban areas, it is an inaccurate reflection of the state-of-the-art in suburban and rural communities. In fact, in rural and suburban communities, the attitudinal issues of adolescent sexuality are just beginning to be dealt with and this process precedes the advent of services. Funds for use by state and local agencies for purposes of coordination will, no doubt, be helpful. Nonetheless, funds for the purpose of coordinating existing services will not supplant the need for services not yet in place.

By way of illustration, all of the agencies that participated in the 1977 NACSAP survey identified infant and child day care as a resource that was critically needed but which was unavailable regardless of the location of the program in an urban or rural area. Other services which the participating agencies viewed as essential but which were largely unavailable as of the spring of 1977 were: 1) group homes and/or

residential care for young women who are unable to remain with their families during the pregnancy; 2) services for adolescent fathers; 3) comprehensive school health/sex education/family life/parenting education courses; 4) decisionmaking training for adolescents; 5) transportation; and 6) long term follow-through support for a minimum of two years following delivery.

With respect to follow-through services, providers have indicated that to effect this dimension of a program, it is essential that staff be available to engage in pro-active outreach with clients or students with whom they have had previous contact in a special program. However, since resources have been limited in terms of responding to young people who are pregnant, minimal attention has been focused on long term follow-through. Yet, it is a central factor as a means of reinforcing the concepts and training afforded by special prenatal programs and it also assures reemphasis of the considerations that influence young people in helping them avoid early, unintended repeat pregnancies.

The services identified above are those which agency staff reported as being needed among service providers participating in the 1977 survey. These services, however, do not by themselves represent the core support which NACSAP recommends as a comprehensive approach for meeting the needs of pregnant adolescents, young parents, and their families. What are these core services? The three key components of a core services approach--each of which is an integral part of any comprehensive strategy--are health, education, and social services. Listed below are the chief elements included in each of these areas. All should be available to pregnant adolescents, young parents and their families during the course of a pregnancy and for a minimum of two years following delivery but will be used by consumers on the basis of individual needs. (NOTE: The costs associated with these services will vary by region, however, on the basis

of information made available by members of our association, it is estimated that a comprehensive approach will cost between $1,500 and $2,000 per client per year for the first year of support.)

CORE SERVICES

A. CLIENTS

HEALTH COMPONENT

General age-appropriate adolescent health services (includes dental and eye care)

Pregnancy Testing

Prenatal Care/Preparation for Labor & Delivery

Nutrition Information

Family Planning Counseling and Services

Pediatric Care

EDUCATIONAL COMPONENT

Regular academic school curriculum (A comprehensive parenting/health/sex/ family life education course is included in NACSAP's concept of a regular academic curriculum)

Vocational Training/Job Placement

Consumer Education

Decisionmaking Training

SOCIAL SERVICES COMPONENT

Individual and Group Counseling
These services are intended to introduce all available options to pregnant adolescents regarding disposition of suspected or confirmed pregnancy.
(NOTE: Refers to involvement of adolescent fathers and extended family units.)

Psychological/Psychiatric Services

Developmental Infant/Child Day Care

Legal Services

Group Homes/Residential Care

Transportation

Financial Assistance (Includes reference to AFDC/MEDICAID support)

Adoption Services

B. SERVICE PROVIDERS

Regular in-service and/or pre-service training for administrators and staff associated with programs serving sexually active youth and young parents. (Basic training courses constitute technical assistance that would help staff develop skills in communicating with young parents and their families; apprise administrators of funding sources and regulations affecting programs; and, suggest means to document efforts, develop linkages, promote public awareness, and develop research designs.)

It is easy to see why comprehensive school-age parent programs are frequently an administrative enigma in view of the range of elements that need to be included in such efforts. However, overlooking any one of these key aspects can result in the breakdown of the service network. Following through on that point, it is important to recognize that H.R. 12146 is a predominantly health oriented bill. As it is now written it overlooks the Core services concept which incorporates health, education, and social services as equal partners in comprehensive program efforts. In fact, without the support from local and state education and social services agencies which has been directed toward this issue for the past several years, it is unlikely we would be here discussing this legislation today. Further, the schools must be looked upon as a central resource for both coordination and direct services to pregnant adolescents and school-age parents. Recognition and respect for the equality of the health, education, and social services partnership at the federal level will, in our opinion, facilitate the cooperation of personnel from all these disciplines at state and local levels and will help achieve successful outcomes for this program. If, however, H.R. 12146 is interpreted and ultimately administered as a predominantly health-based program, our experience would suggest that important contributions and the needed cooperation from associates in the fields of education and social service

will not be effected. This is especially significant when considering which institution has the greatest access to the young people, namely, the school.

I want to also make a point concerning Section 102 of H.R. 12146, specifically Item #6 pertaining to the use of grant funds for providing training. The proposed bill excludes support for institutional training or training and assistance provided by consultants. It appears that the idea is to draw upon the expertise of personnel presently associated with existing programs. In identifying core services for a comprehensive school-age parent program you will observe that NACSAP differentiated between the needs of clients and those who are working directly with young people. In-service training has been one type of technical assistance which NACSAP has offered in its program over the past few years often through specialized training courses and at other times through national conferences or individual consultant services. For example, to date, NACSAP has helped to develop and conduct state and regional in-service training course in Oregon, Washington, Maryland, Louisiana, Texas, West Virginia, Illinois, Colorado, and Pennsylvania. In the case of Colorado and Pennsylvania, our representatives were participating as staff in regional programs developed by the Department of Health, Education, and Welfare. The course content was generally designed to help professionals and others who are working with sexually active youth and young parents reach an understanding about their own values and perceptions of self, sexuality, and parenting so that they can relate more effectively to young people and their families. In some instances the courses offered have been accredited by higher education institutions (e.g., University of Oregon, University of Texas/Galveston, and Eastern Washington State College at Cheney). Instructors in these courses have, in some cases, been independent consultants selected on the basis of their relevant expertise.

On the basis of its experience with these training programs, NACSAP recommends that a waiver clause be added to Item 6 to allow the use of funds for training by institutions and/or consultants pending review of the grantee's training methodology and faculty.

Item #6-E of Section 102 (Uses of Grants) imposes another restriction limiting any grantee from using in excess of 50% of its grant for services. Though a waiver is allowed, on the basis of the case made earlier about the lack of services in several communities, especially in suburban and rural areas, NACSAP strongly recommends that this restriction be revised to permit a grantee to use up to 75% of a grant for direct services.

NACSAP proposes two recommendations relevant to Section 104 of H. R. 12146 (Requirements for Grant Approval). First of all, a maintenance of effort clause needs to be added. In effect, this would be an insurance premium to guard against the possible redirection or withdrawal of existing state, local, and/or private funds that were previously generated to meet the needs of this population. This recommendation is made on the basis of a fundamental understanding and appreciation for the sensitive nature of adolescent parent programs and in recognition of the fact that in the context of other human service concerns, this is yet a relatively low priority in most communities.

The second consideration is with reference to Item #6 in Section 104. As written, this Item requires grantees to describe how adolescents needing services other than those provided directly by the grantee will be identified and how access and referral to those services will be achieved. Included in the services described as "other" is infant, day and drop-in care services for adolescent parents. Infant day care cannot be viewed as a luxury service for adolescent parents. It has been proven among our

constituents to be central to the concept of comprehensive services. Without it, the efforts to provide coordinated prenatal services are destined to a short-term impact, an impact which, for all practical purposes, terminates at the point when the adolescent mother who has delivered her baby and has kept the child (approximately 90% of the over 600,000 adolescents who carry pregnancies to term are estimated to be keeping their babies rather than placing them for adoption) attempts to return to school and finds there is no one to care for the baby when she returns to classes. As a central element in the core services program, developmental infant day care is difficult and costly to provide. However, some states, e.g., California, and local communities, can demonstrate that this is not an impossible resource to provide. NACSAP recommends, therefore, that infant/child day care be deleted from Item #6 (where it is referred to as other) and, inserted in Item #5 (Section 104) which includes a listing of core services.

Title II of H.R. 12146 (Improving Coordination of Federal and State Program) notes that the Secretary of DHEW will set aside up to 1% of the funds in this program for evaluation. From NACSAP's perspective this would appear to be an extremely limited allocation for an especially important aspect of comprehensive programs. The knowledge base concerning these programs is limited and predicated on the results of very few intervention strategies. NACSAP recommends that a minimum of 3% and a maximum of 5% of the funds be set aside for evaluation. Further, in the regulations, a definition of the evaluation design and the means for monitoring the evaluation components of the programs funded should be provided with appropriate means of adaptation to health, education, and/or social service-based approaches. All grantees should be required to incorporate an evaluation component in proposals for funding before qualifying for competition.

There are several references to technical assistance in H.R. 12146 which NACSAP believes to be a pivotal point in terms of the potential for success of the program in general and specifically in terms of the outcomes for individual grantees. Technical assistance plans must be developed for use by federal, state, and local agencies that are working in this field. At a minimum, the technical assistance associated with the program resulting from this legislation should make available to interested persons the following:

1) guidelines for needs assessment at state and local levels;

2) recommended procedures for developing and/or coordinating core services;

3) identification of research and evaluation techniques appropriate to various program designs; and,

4) suggested formats for documenting efforts on short and long-term bases.

In the work that NACSAP has been involved in in nearly 40 states over the past several years and through the network of programs with which the organization is associated, this is an area which we know to be vitally needed for getting a program started and then sustaining it. Without technical assistance resources such as those described, it will be difficult for H.R. 12146 to be effected successfully. NACSAP would hope to make a meaningful contribution to this part of the program.

In summary I would like to affirm once again NACSAP's general support for H.R. 12146. I would further emphasize and underscore, however, the need to strengthen this measure along the lines suggested so that a new program, were it to get underway, would not detract from or encumber the steps which have already been taken to prevent adolescent pregnancies and/or to treat the needs of families involved in such a circumstance. This bill places considerable responsibility in the hands of those who

develop the regulations and subsequently chart the administrative course. Because of the complexity of such an effort as it relates to pregnant adolescents and young parents, which I hope has been characterized in my testimony, NACSAP's final recommendation is that DHEW be required to develop regulations and conduct this program in concert with an Advisory Committee comprised of persons with expertise in the provision of services; research and evaluation; and/or policymaking with respect to this population. Consumers should also be represented on this Committee. Without such a Committee, a Committee that could also relate to the other elements of the Teenage Pregnancy Initiative, it will be extremely difficult to implement this program. Personally, I am skeptical that the breadth and depth of expertise that is needed in such a comprehensive effort is in place at the Department of Health, Education, and Welfare at the present time.

Mr. Chairman, I am pleased to have had the opportunity to join the other witnesses in appearing before you today on behalf of young people who are at risk of pregnancy as well as on behalf of adolescent parents and their families. It would appear that H.R. 12146 has its greatest potential, if focused, as a beginning effort to address the needs of pregnant adolescents and young parents. NACSAP looks forward to working with you and other members of Congress and the Administration in promoting a comprehensive, cost-effective strategy which results in a successful, compassionate, and much needed program which cannot conscionably be delayed. Thank you for the opportunity to testify.

attachment: NACSAP MEMBERSHIP BROCHURE

STATEMENT OF

AMERICAN CITIZENS CONCERNED FOR LIFE

BY

MARJORY MECKLENBURG

FOR

THE HOUSE SUB-COMMITTEE ON HEALTH AND THE ENVIRONMENT

ON

"THE ADOLESCENT HEALTH, SERVICES AND
PREGNANCY PREVENTION AND CARE ACT OF 1978, H.R. 12146"

JUNE 28, 1978

Rep. Rogers, members of the Subcommittee on Health, I welcome the opportunity to appear before you today as president of American Citizens Concerned for Life, a national pro-life organization, to speak in support of the "Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978," H.R. 12146.

ACCL has had a long-standing interest in pregnant women, children and the family. Our overall purpose is to motivate each individual, and society as a whole, to make decisions about the use of available resources based on the premise that each human being has great value and that individuals should have the opportunity to realize their full potential.

ACCL is an advocate for both public and private sector programs to improve and safeguard the lives of pregnant women and children -- both before and after birth. During the 94th Congress I testified in behalf of bills authored by Sen. Kennedy and Sen. Bayh which focused on these needs. With your permission I would like to enter those statements in the record of this hearing along with testimony I presented last March before the House Select Committee on Population.[1]

The number of adolescent pregnancies and the problems surrounding this phenomenon have been of growing concern to the Administration, members of Congress and the public. About one million adolescent girls -- one in ten aged 15 to 19 -- become pregnant each year, the majority out of wedlock. Of these one million girls, 400,000 are 17 or under; 30,000 are 14 or under. While some teenagers are married and wish to become pregnant, a substantial

[1] The following materials were presented to the Select Committee on Population, United States House of Representatives, March 1, 1978:
Testimony of Marjory Mecklenburg, president, American Citizens Concerned for Life,
Statement of Marjory Mecklenburg, president, American Citizens Concerned for Life, and
Responses by Marjory Mecklenburg to supplementary questions.

number of teenage pregnancies are unwanted; well over 300,000 teenage abortions were reported in 1976 to the Center For Disease Control.[1] Dr. Wendy Baldwin, social demographer from the National Institute of Child Health and Human Development, in her statement before the Senate Human Resources Committee on June 14, reported that for adolescents "birth rates are still high, increasing numbers of births are out-of-wedlock, control of fertility is still poor, and the exposure to risk is increasing."[2]

H.R.12146 will make available services which adolescents need to avoid becoming pregnant or to continue a pregnancy already begun, and we support the bill on this basis. We believe that adolescents who choose to continue a pregnancy despite the hardships they encounter are deserving of our compassion and our practical assistance. "Freedom to Choose" implies that it is equally possible for a woman to choose to give birth as well as to abort. Today frightened, confused and dependent adolescents often have little freedom to continue a pregnancy unless the kind of services this bill details are readily available.

Most pregnant adolescents and their babies have a bleak future. The adolescent faces a multitude of phychological, psycho-social and health complications as a result of early pregnancy. These young women have to cope with the developmental tasks of adolescence, while shouldering the demands of early childbearing and rearing. Some of the girls who are pregnant at this early age have multiple problems, such as unstable family backgrounds, and low self-expectation and esteem. Unless the pregnant adolescent receives adequate counseling and services she may become phychologically impoverished (depression and suicidal attempts), a school dropout, have repeat pregnancies, or become a vicitim of unemployment and long-term reliance on welfare.[3,4]

Many girls who are pregnant out of wedlock do not report for medical care until very late in pregnancy. Therefore, a vast majority of them receive inadequate health care and are undernourished. When this is the case, they face significant risks both for themselves and for their babies.

They are more susceptible to death from toxemia of pregnancy (maternal mortality is 60% higher among teenagers who do not receive adequate prenatal care).[3] Their children are more frequently premature, and often have such complications as increased susceptibility to infections, hypoxic brain damage, nutrition related congenital defects, and developmental disabilities, including mental retardation and learning disabilities. Infant mortality can be as much as 2.4 times higher for babies born to teenagers than to 20-24 year old mothers.[4]

As we investigated what is being done to assist the adolescents who are facing this crisis, we concluded that a comprehensive approach which provides both medical care and psycho-social support can dramatically improve the outcome for both mother and baby. With adequate medical care, attention to nutrition, and help in psycho-social areas most of these women will deliver safely.

However, the needs of pregnant adolescents are so diverse and complex that a program directed at only improving medical care has proven to be inadequate. Adolescents in general are notably poor users of health care services, and pregnant adolescents in particular are sporadic users of prenatal care. This may be because of ignorance, fear, or negligence. They may have

anxiety about possible ostracism or judgmental attitudes by adults. They often see existing services as not meeting their needs and thus not "approachable."

But when their psycho-social needs are met and adequate counseling and support are available in combination with medical care there is evidence that adolescents will report early for prenatal care and will keep appointments with the physician.

It is important to provide excellent care for this age group in a place that is comfortable for them -- a place in which they may have had a previous positive experience is ideal. For example, when comprehensive care centers are located in schools, the girls tend to come in early for pregnancy care. The teenage grapevine and referrals often inform the pregnant girl where helpful supportive services can be found.

The basic components of successful comprehensive adolescent pregnancy programs are:

1. Early detection of pregnancy and comprehensive prenatal care.
2. Social services to help adolescents cope with emotional, financial and community problems.
3. Comprehensive health care for the infant.
4. Long-term follow-up services for a minimum of two years.
5. Education -- to encourage completion of schooling and provide parenting and family life instruction.
6. Adequate day care.
7. Procedures for involving fathers.

8. Involvement of community supporters.
9. Staff training and education.
10. Transportation resources.
11. Prevention of pregnancy.
12. Evaluation methods to determine success or failure.

Providing comprehensive services to pregnant adolescents appears to be realistic and cost effective over both the long and short term. Girls who utilize comprehensive programs are less likely to have repeat out-of-wedlock pregnancies and they are less likely to rely on welfare assistance programs for long periods of time. Adolescent mothers who receive adequate medical care have a lower rate of obstetrical complications which would affect their health and that of their children.[5,6]

There is evidence that comprehensive care programs are also an effective means of reducing the number of first pregnancies in the community of adolescents who have contact with such programs. Failing to allocate the resources necessary to provide comprehensive care for pregnant adolescents will result in the need to expend even more to deal with the resulting consequences.

Few pregnant adolescents have access to comprehensive programs. Model programs are available in very few areas. Even where services exist in a community the different elements may be scattered and coordination may be lacking. Young women may not know how to find the assistance they need. Continuity is an important factor in treating adolescents and through this legislation various agencies will be encouraged to seek more coordination and cooperation so that the pregnant adolescent is considered as a whole

32-794 O - 78 - 9

person. We believe that there is a strong case for both more services and better linkage of already existing services.

Because the need for supportive services for pregnant adolescents is urgent and the comprehensive approach has been shown to be effective we would favor increasing the funding authorization in this bill. We would also recommend that the percentage allocated to evaluation be increased. As representatives of the voluntary sector we believe it is crucial that a citizen advisory committee to HEW be formed to recommend guidelines for these programs and to assist in evaluating them. This committee should be broadly representative of the groups that are interested and involved in such programs, and of the people being served by the programs. One of the strengths of this bill is its attempt to involve communities, to allow them flexibility, and to encourage their eventual assumption of responsibility for funding and control. This process will be hastened if a mechanism for ongoing interaction is established between providers and advocates in the field, those being served, and professionals in HEW who are administering the programs.

In addition to authorizing supportive health services and care, H.R.12146 also provides for pregnancy prevention programs, although it is not clear what percentage of the funds is intended for that purpose. Surely, there is general agreement that prevention is an important aspect of dealing with the problem of adolescent pregnancy. Of the one million adolescents who become pregnant each year abortion statistics would indicate that many did not wish to become pregnant but were not sufficiently educated or motivated to prevent it. Unless we discover effective ways to encourage responsible sexual behavior in the

adolescent population, this situation is unlikely to change in the near future. Dr. Wendy Baldwin reports that "Between 1976 and 1980 we can expect the number of 14-17 year olds to decrease by 6.7%. If the proportion of those who are sexually active continues to increase, however, the net effect may well be an increase in the absolute number of adolescents at risk of pregnancy."[2]

Surely such a situation is unacceptable. The high degree of sexual freedom that exists in our society today calls for increased personal responsibility and self-control. Yet we have not been able to give young people the kind of help they need to live in such a climate and cope with their own sexuality.

Traditional family planning programs have not provided the kind of approach many young people are seeking. Even where such services are readily available they may not be utilized by sexually active teens.[7] In addition, the possible adverse effects of long term usage of IUD's and oral contraceptives are a matter of growing concern, as are the other medical problems faced by sexually active teens.[8]

We must develop educational approaches to pregnancy prevention which will focus on sexuality in the broader context of life experiences. It is important to place family planning and human sexuality education in such a context and to structure programs so that they are not isolated technological services devoid of morality, family involvement and other elements that are crucial in an adolescent's life.

I personally don't believe that anything is gained by withholding family planning services from adolescents after they are sexually active. Such a

policy only increases the possibility of pregnancy, pressure for abortions and other problems sexually active adolescents may have. However, contracepting adolescents is not the only or optimum solution to preventing adolescent pregnancy. Many of us would like to see programs which would encourage young people to choose to value themselves and their sexuality and to postpone sexual involvement. Yet today there appears to be little emphasis on this approach and little encouragement for adolescents who choose this option. Current role models tend to glamorize the sexually active teen.

It would be our position that the primary prevention funds made availalbe through passage of this bill should be directed at research and development of model programs to foster new and comprehensive approaches to preventing adolescent pregnancy. Contraception programs are substantially funded through other federal legislation.

In summary, we in ACCL believe there is a strong case for passage of this bill. The voluntary sector is responding to pregnant adolescents but has not been able to adequately meet the complex needs of these troubled individuals without governmental assistance.

Your recognition of the problems they face and your stimulation of appropriate services will substantially improve the future for many young mothers and their babies.

REFERENCES

1. Califano, Joseph A., Testimony Before the Senate Human Resources Committee, June 14, 1978.

2. Baldwin, Wendy, Testimony Before the Senate Human Resources Committee, June 14, 1978.

3. Youth Alternatives, Vol. IV, No. 11, National Youth Alternatives Project, Washington, D.C., November, 1977.

4. Family Development Program, submitted to HEW Secretary Joseph A. Califano by a Special Task Force, March 17, 1977.

5. Edwards, L. E., An Experimental Comprehensive High School Clinic, unpublished paper, St. Paul, MN, 1977.

6. Hardy, J. B., The John's Hopkins Center for School Aged Mothers and Their Infants, Annual Report 1976-1977, January, 1978.

7. Zelnik, M. and Kantner, J., "Contraceptive Patterns and Premarital Pregnancy Among Women Aged 15-19 in 1976," Family Planning Perspectives, Vol. 10, No. 3, May/June 1978.

8. Kistner, R., speech at Annual Clinical Congress of American College of Surgeons, reported in OB/GYN NEWS, December 15, 1977.

CONTENTS

STATEMENT ON MEETING THE NEEDS OF
PREGNANT WOMEN AND THEIR FAMILIES

An Examination of Life Supportive Policies
in the Public and Voluntary Sectors

by

Marjory Mecklenburg, President

American Citizens Concerned For Life, Inc.

Presented to the
Subcommittee on Constitutional Amendments
Committee on the Judiciary
United States Senate

June 19, 1975

STATEMENT ON COMMUNITY SUPPORT

For

The National School Age Mother and Child
Health Act of 1975 and
the Life Support Centers Act of 1975

by

Marjory Mecklenburg, President

American Citizens Concerned for Life, Inc.

Presented to the
Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate

November 4, 1975

STATEMENT ON MEETING THE NEEDS OF PREGNANT WOMEN AND THEIR FAMILIES

An Examination of Life Supportive Policies in the Public and Voluntary Sectors

My name is Marjory Mecklenburg. I am the President of American Citizens Concerned for Life, Inc. (ACCL), a national organization which seeks to promote respect for human life and to work for its enhancement. Testimony presented at a previous subcommittee hearing by ACCL outlined our philosophy on a broad range of the life issues. We are pleased that you have invited us to present further testimony today on the specific topic of alternatives to abortion.

Senator Bayh, many people are disturbed by the rising tide of violence in this nation. Americans are subjected to violence on the streets and on television and movie screens. Congressional hearings on violence in our schools have recently been completed. The subject of violence has a great deal to do with what we are discussing here today. Abortion, the destruction of unborn human offspring, is a violent act. This violence to unborn children has become a widespread and legal practice that is publicly funded and promoted in our country.

We in ACCL believe that our nation is capable of a loftier public policy — that our women deserve much more than the right to destroy. And that our nation's children, both born and unborn, have the right to protection and nurture by our great government. .

Senator, we are pleased that your Subcommittee on Constitutional Amendments has not only chosen to hold lengthy and balanced hearings on a constitutional amendment dealing with the rights of the unborn, but that you have, in addition, focused today on the real problems faced by pregnant women and their families.

Most of the testimony offered during the course of these hearings has been focused on the two poles of argument which underly the controversy over abortion. Those who share ACCL's concern about the loss of the right to life of unborn babies have focused on the need for re-establishment of that legal protection. Those speaking against the enactment of a Human Life Amendment have promoted what they believe to be the right of a woman to preserve her privacy by aborting her pregnancy. Abortion proponents have also argued that in order to prevent discrimination of poor women the procedure must be both legal and reimbursable through public funding.

This sharp polarization has resulted in a degree of bitterness. We at ACCL have observed that additional subtler negative effects have taken place in the midst of the furor aroused by legalizing abortion. These effects have been deleterious to the pregnant women who decide to give birth to their babies.

We need to ask what the conditions of life are which confront women who are troubled by an unintended pregnancy but who do not choose abortion. What are their rights? What is society's duty to them and to the children they will bear? Are we meeting that duty? Or have these women been largely ignored by the public sector and much of the private sector, and been pushed into the background or eliminated totally from the abortion debate? We believe that they have been ignored, and that they constitute a disadvantaged class suffering a special kind of discrimination.

We believe that the abortion question centers around human rights — their interpretation, and their denial. We believe that the unborn child lays claim to certain human rights merely by the fact of his existence, judicial fiat notwithstanding. But we also know that in whatever social or legal climate his life begins and moves toward birth, his mother is his first line of defense against pre-birth aggression. It is literally with her that his life rests. Regardless of the state of the law governing the relative rights of the mother and child, Americans must examine the pregnant woman's life situation, assess what is necessary to preserve her personal dignity and her mental and physical health, and then provide for these needs. If we neglect to do so, then we must seriously ask ourselves if we have not been to blame for the loss of many unborn infant lives and possible ravages upon women and the family through our apathy and neglect. Women must not be forced by circumstances to seek an abortion because of an implied national policy against life and the lack of an acceptable alternative. A society that truly cares for all its people will see that the pregnant woman who gives birth to her baby emerges from the experience as a strong, independent individual.

COUNSELING FOR LIFE SUPPORT

Medical, legal, psychiatric, spiritual and other counseling should be immediately available to any woman and family who face a distressed pregnancy. In today's climate, often the first contact the troubled pregnant woman has is with an intake person at an abortion clinic, or a minister associated with the Clergy Consultation Service (CCS), founded to provide abortion information.[1] These intake situations are widely advertised and available. Criticism has been leveled at such abortion-related counseling services by pro-life advocates, who allege that women who are clients of these facilities are receiving counseling framed in a way which makes an abortion seem to be the most attractive option by emphasizing its alleged safety, the relative low cost of the procedure when compared to maintenance during pregnancy and delivery and the relative assurance of anonymity. There may be no attempt at full disclosure of the facts of fetal development, the nature of the operation, the possible complications to the woman both of a physical and psychological nature, and the assistance available if she chooses to continue her

pregnancy. Despite the purpose and activity of these abortion counseling clinics, many of them enjoy tax-exempt, tax-deductible IRS status which is normally reserved for educational or charitable ventures.

The pro-life sector of society has attempted to provide alternatives to these abortion intake services with crisis "hot line" telephone setups and backup referral services for pregnant women. Much more investigating, planning, and funding needs to be done to make professional life supportive services available to offset the more available and well-financed abortion promotion system. In most areas of the nation, individuals working in referral organizations such **Alternatives to Abortion** or **Birthright** are unsalaried, raise their own funds, staff telephones, conduct training sessions, and do a generally excellent job with limited resources. There is no lack of dedication — these workers are among the most committed and industrious in the prolife movement. Their clients must look for backup services to inadequate pre-existing support systems. No amount of hard work and dedication can match the millions of dollars in private foundation funds and federal grants for abortion programs that clinics and hospitals enjoy.

Non-medical difficulties which may confront a pregnant woman should be of as much concern to the social services worker, physician, or counselor as any medical complications which may be encountered. During the early months of pregnancy, it is not uncommon for many women to react with fear, resentment and depression. Positive feelings of acceptance develop as the pregnancy advances and fetal movements are detected. Pressure to abort due to the psychic strains of the early months can generally be reduced by sympathetic and patient supportive counselling. A woman should be able to rely on the assistance of a continuing caseworker, who can follow her through the pregnancy, visit her after delivery, and continue to assist in post-partum adjustments. Money should be made available by the federal government to "life-supporting" organizations to ensure that this kind of comprehensive counseling is available to all who need and request it.

The "intensive care" concept is applicable to and necessary for the troubled pregnant woman. There are wide differences in the needs of different patients. A "supermarket of services" should be both widely advertised and readily available (free, if necessary) to enable the woman herself to select those services which best suit her needs.

UNWED MOTHERS

Education. Services to unwed mothers, many of whom are students, should be designed to eliminate the social stigma which much of our society still places on single parenthood. Many school systems, both public and private, insist that single pregnant girls leave regular class settings and enter special segregated classes — segregated in the sense that only pregnant girls can attend. This, in effect, is a labelling experience if the girl does not wish to enter such a class, and can be interpreted by her as society's "punishment" for her pregnancy. The baby's father, often also a student, is never subjected to such segregation or notice.

A strong emphasis should be placed on encouraging pregnant students to continue with their studies. They should be able to choose whether they prefer to remain in regular classes, or to attend a special school, or even to receive homebound education. Both federal and individual state legislation must be enacted providing that pregnancy, parenthood, or marital status cannot constitute grounds for denial of education.

Parenting Skill Training. A regular academic or vocational curriculum is only one kind of training a young pregnant mother may need. During pregnancy, personal motivation is high for acceptance of practical courses in parenting and homemaking skills. Most unwed mothers keep their children. Comprehensive training in the skills needed to manage the basics such as "how to bathe the baby", as well as the other myriad details that constitute the art of parenting, are necessary to help young mothers fully understand and cope with stresses of everyday living with children. Classes should be informal and innovative, and encourage actual participation of the students in selection of some of the curricula.

The pregnant woman who is motivated to learn how to adjust to her changing life, including the fact of her pregnancy, is also more receptive to the information offered by private organizations such as the International Childbirth Education Association (ICEA) and the La Leche League (LLL). On request, such groups will gladly provide training for understanding of pregnancy and delivery, infant nutrition, and basic mothering arts. Cooperation between the public and voluntary sectors interested in parenting skills training should be encouraged by educators.

THE VERY YOUNG UNWED MOTHER

The problem of pregnancy in the very young unprepared woman is compounded by the complexities of subliminal motivations for teenage pregnancy. It seems clear that we are not able at this time to prevent pregnancy from occurring among young teenagers in this country. These young mothers are thrust into an adult world with the responsibility of raising a child while minimally equipped to handle the pressures with which they will surely find themselves surrounded.

Out of wedlock pregnancies may not be unintended.[1] Refual to use restraint or contraception is an all too common practice among teenagers. Without developing a full-blown discussion in this testimony of the reasons for such behavior, it is ACCL's firm conviction that pro-life organizations must work together with groups such as the Child Welfare League of America, the National Alliance Concerned with the School-Age Parents (NACSAP) and others to work vigorously for special services of the highest quality for these young mothers and their children. The very young mother is quite likely to have little or no idea about the nature of responsible parenthood and perhaps even less insight into the reasons for her own actions and attitudes which have led to the pregnancy.[2] The single young mother often struggles to survive on meager funds, isolated from her peers, alienated from her family, and stunted in her emotional and social development. The children of such parents may suffer even worse deprivations.

The hard fact is that these young mothers exist in large numbers. The Child Welfare League's **Consortium on Early Childbearing and Childrearing**, an interagency project which was funded by DHEW, has compiled information designed to help states, communities, and individuals identify and serve the needs of school-age parents. The "Education for Parenthood" program, under DHEW, is a hopeful new venture. There are signs that it is possible to

create services which may help these young mothers. We believe that by working together, the public and voluntary sectors can do much to prevent the abortion of infants already conceived by young teenagers. Further unwanted pregnancies may also be reduced by involvement after the child is delivered to assist the young mother's development into a woman who is able to make responsible decisions about both her own and her child's future.

NUTRITION AND OTHER SPECIAL NEEDS

Malnourishment of the pregnant mother and her unborn child is a major contributing factor to premature birth. The **National Foundation — March of Dimes** Annual Report for 1974 states:

> "Low birthweight is the underlying or contributing cause of half the deaths of United States infants. It is unmistakably as serious a cause of death as the gravest birth defects. Several recent studies show that low birthweight is closely linked to medical and social risk factors. About 7% of babies born to mothers who are at no risk weight 5.5 pounds or less. The ratios of low-weight babies born to mothers at medical and social risk, respectively, are 11.1% and 11.6%. **Fully 15% of infants born to mothers who are at both medical AND social risk are low-weight** (emphasis added).
>
> The studies show even more dramatically that infant death rates rise sharply, depending on the degree of risk; infant mortality in the no-risk group is only 11.9 per thousand live births; it rises to 24.4 per thousand for the social risk group; 27.3 for women at medical risk, **and an appalling 41.6 per thousand for those who are at both medical and social risk"** (emphasis added).

Abortion proponents have claimed that infant mortality has been reduced by making abortion available to the poor. The above statistics on infant mortality for women at medical and social risk — i.e., the poor — challenge that claim. Something is happening — or is not happening — to perpetuate patterns of discrimination toward poor pregnant women that make them a uniquely disadvantaged class. Most poor women coping with an unintended pregnancy, regardless of medical status, fall into the high risk category due to the complex nature of the basic difficulties with which they must cope.

As a result of the U.S. Supreme Court decision in **Burns v. Alcala,** the welfare mothers in 38 states can receive no funds for the benefit of the child until it is born. The Court's majority opinion cites the legislative history of the Social Security Act and uses the 1935 record of debate to argue in favor of denial of benefits directly to an unborn child.[3] It is a simple fact that the presence of the unborn child's dependent intrauterine existence alters its mother's own needs. In the economic climate of 1975, those needs are extremely compelling and it may be impossible for an unassisted pregnant woman to fill them. Ignoring the changing nutritional needs of a pregnant mother courts disaster — socially, humanly, and economically — in the form of possible lowered mental ability of her child. The infant's brain and nervous system develop most rapidly during the last trimester of pregnancy. It is then that malnutrition will work its worst ravages on both baby and mother, ravages we can never fully repair regardless of subsequent investments in services and treatment.

Special Needs. The changing body of a pregnant woman requires that she adapt her wardrobe, and in most cases she must obtain entirely different clothing. Her self image may have already suffered severely due to desertion by the baby's father and perhaps by her family and friends. Yet this self image is important to her mental well being. Women who have borne children know that maternity clothing needs are more than just a smock or two. Special underclothing, a warm sweater knit to button properly, a full-cut coat — all are items that may seem unimportant or unnecessary unless the total needs are scrutinized.

Many voluntary pro-life groups have attempted to provide clothing and other incidentals insofar as they are able. Consideration of the undeniable facts that pregnant women do require special foods, clothing, and sundries should encourage legislation which provides special provisions for increased support levels for these women.

ACCL firmly supports two-person, or two-party, payments for pregnant women under AFDC, and urges that geographic discrimination against poor women by the denial of the second payment be ended by the enactment of appropriate state or federal legislation.

CHILD CARE SERVICES

ACCL recognizes the need for the provision of child care services for parents who must leave their homes to work or to further their educations. We view the well-run day care facility as a positive alternative to abortion. For many frightened pregnant women, the knowledge that they may be unable to work or attend school, and thus be forced to seek welfare support, is sufficient motivation to seek abortion.

The need for the creation of hundreds of thousands of new spaces for child care has been well documented. We refer the Subcommittee to the statement of Joseph H. Reid, Executive Director of the Child Welfare League of America, before the Senate Subcommittee on Children and Youth for up to date statistics and rationale for expanded day care services.[4]

Care for children under the age of three years presents special problems, in that the child-adult ratio must be very low to achieve the individualized care necessary for healthy mental and emotional development.[5] At present, this kind of service is lacking in most day-care service programs, and yet it is the most needed for the new mother if she is not to become a candidate for continuing public assistance. We urge that efforts continue to provide adequate child care services for all who need them. Such centers should be sensitive to, and respond to, needs and desires of the members of the community in which they are established. As in any cooperative facility, parents should spend a fixed amount of time assisting at the child care center, observing the children in the group setting, and attending informational meetings concerned with the facility's program. This will help to ensure the development of programs designed to best serve the needs of children.

ACCL encourages the development of child care facilities in suburban communities and rural areas, as well as congested urban areas. Travel time is often a significant factor in the lives of parents who work or attend school, and distance of the child care facility from the home should not constitute an undue hardship or make it impossible for the parent to avail herself of the services.

S.626, otherwise known as the "Child and Family Services Act of 1975", and its House counterpart H.R.2962,

have been drafted to address the needs briefly outlined above. ACCL is pleased to note that the Chairman has long been interested in child care services. Two members of the ACCL Honorary Board — Senator Mark Hatfield and Rep. James Oberstar — have joined in sponsorship of these bills, and we urge that all pro-life congressmen support these or similar child care provisions.

RAPE TREATMENT AS AN ALTERNATIVE TO ABORTION

We are pleased that there is a growing interest in the problems of the rape victim. Provision of abortion for rape need not be written into law since women given adequate medical treatment for rape will not become pregnant. What is most important is ready access to rapid, compassionate, nonjudgmental handling by police officials and involved medical personnel.

We encourage legislative action directed toward the problems of rape victims such as that proposed in H.R.3590, introduced by Rep. John Heinz, which is a bill to amend the Community Health Center Act to authorize a program for rape prevention and control. If this bill becomes law (its Senate counterpart has already been passed as a part of S.66) a Center for the Prevention of Rape will come into being under the auspices of the National Institute for Mental Health.

Aggressive and comprehensive programs such as that embodied in this bill can be considered as a definite alternative to abortion.

POST-ABORTAL COUNSELING AS A DETERRENT TO RECIDIVISM

Abortion proponents maintain that the psychological aftereffects of an abortion are minimal or nonexistent. They make these claims despite the fact that no definite long-term studies demonstrating this hypothesis have been undertaken in the United States. Caseworkers, clergy, and others who have had to handle post-abortion psychological sequelae know that such complications do occur. Frank Ayd, M.D., a psychiatrist, recently told the United States District Court for the Eastern District of Pennsylvania:*

> "Usually adolescents come in for late abortions, some of them to the point that they have already felt fetal movement, so that they know that in fact they are pregnant, and they have gone through this period of should I or should I not, and if they have been pressured by a putative father or by their parents or by anyone else to make a decision to go ahead and have an abortion and yet, at the same time, they want to have the baby. They have an abortion without resolving the conflict in their own mind. Consequently, after the fact, when the sense of relief has passed and the emotional turmoil has settled down and they begin to reflect on what they have done, they may go through a period of remorse and regret and feelings of depression.
>
> "Now, this can occur, for example right before menstrual periods. That can refresh their memories. It brings back all of the conflicts that they have lived through earlier. You can see some have what we call an anniversary reaction, meaning by that the anniversary of the day of the abortion. They could become quite upset around that time or the anniversary of what would have been the birthday of the baby that they are not now going to have because in their mind they have destroyed this baby.
>
> "I think the important thing, to put it this way technically, we can scrape the baby out of the womb of the mother, but we can't scrape it out of her mind and since it's in her mind, there are going to be various things which will remind her of the fact that she once was pregnant, once was in fact a mother, and that she has terminated this, and depending . . . on . . . her religious upbringing, her particular sense of values, her maternal instinct, how much support she has from her parents, and other important people in her life, then the recollection of having had an abortion can serve as a trigger for all sorts of emotional problems. She can look upon herself as a murderess. She can look upon herself as a person who took the easy way out at the expense of somebody else. It depends — you see, there are so many variables, because you are talking about an individual whose level of intelligence, whose education, whose religious values, all of these things play a role in when and how she's going to respond to the realization that she's had an abortion."

Mrs. Sherri Finkbine Burrows, who went to Sweden for an abortion in 1962 after learning that she had inadvertently taken the teratogenic drug thalidomide, has publicly stated that she suffers from lingering guilt feelings* and she attempts to help other women cope with post-abortion mental and emotional problems.

If it is debatable whether there are post-abortal psychological sequelae, we should be trying to find out the extent of and frequency of such complications through long-term unbiased studies. Has the federal government initiated any such study? ACCL feels that Congress should register its concern over the inconclusive data brought forth to date regarding abortion-related mortality and morbidity (as distinct from that of death and/or medical complications in childbirth), infant mortality among various socioeconomic groups, post-abortal physical and psychiatric sequelae, etc., by undertaking a number of very thorough long-term research projects to study the ultimate impact. ACCL and other pro-life organizations feel strongly that equity and fairness demand that research programs involving abortion data should include professional personnel of the pro-life persuasion as well as proponents of legalized abortion.

GENETIC COUNSELING AS AN ALTERNATIVE TO ABORTION

ACCL supports the concept of making genetic counseling available, (free, if necessary), to any person of childbearing age who has a legitimate concern about his or her ability to produce normal children. Advising couples of genetic risk **before** they begin a child's life can do much to help them decide whether they wish to assume the statistical risk of their offspring inheriting metabolic or structural defects. We feel that procedures designed to diagnosis intrauterine illness in the unborn child are laudable, as long as the intention is to treat, and not to kill the child if it is found to be imperfect. Making it acceptable to kill the imperfect baby in the womb lays the foundation for the direct killing of the defective newborn infant. Shouldn't we instead place an emphasis on pre-conception counseling and on providing helping measures for women and families

raising children with problems? The **Handicapped Education Act,** reported unanimously by the Select Subcommittee on Education, was introduced into the House of Representatives on May 21, 1975. Rep. Albert Quie, an ACCL Honorary Board member, is a prime sponsor of this bill. We point to this type of legislation as the kind which will enable parents to know that the intent of Congress is to offer tangible help in troubled situations. This bill, and others that are similar, can help to prevent the abortion of the imperfect by assuring parents that their handicapped child will be able to claim his or her full right to be educated.

Both couples and single mothers should be able to purchase some type of birth-defect insurance during early pregnancy, so that if they do have a defective child, the cost of special medical care and training can be borne more readily. The few policies available today are prohibitively expensive, and set unrealistic ceiling on the funds available for medical care. We encourage legislators to consider birth-defect coverage as an integral part of any comprehensive health plan.

FAMILY LIFE AND SEX EDUCATION AS ALTERNATIVES TO ABORTION

Few subjects have aroused as much impassioned debate in America as education in human sexuality. Arguments over curriculum content, qualification of instructors, and values advocated have flared repeatedly. Depending on one's point of view courses maybe either too permissive in attitude, or not explicit enough, or place undue emphasis on demonstrations of contraceptive techniques to youthful students.

Largely overlooked is the fact that, regardless of the subject matter and the manner in which it is presented, few studies have been done to determine what have been the actual effects of sex-oriented education. Has the incidence of unintended pregnancy dropped or increased among students who have received detailed instruction? Does exposure to discussion about sexual intercourse, contraception, sexual orientation, etc., encourage young people to feel that if it's permissible to discuss these matters publicly it's permissible to begin sexual activity? Has the divorce rate gone up or down as a result of sex education? Are people better adjusted in marriage if they have studied human sexuality? Are there qualitative differences between courses teaching clinical information in a "value-free" manner as opposed to courses emphasizing responsible parenthood and the use of one's sexual powers as integral components of responsible action? We do not really know the answers to these various important questions, and the answers must be found before we proceed further in developing new courses of study.

Without ascertaining the results of our past and present teachings, how can we continue to develop new curricula that will ultimately contribute to the betterment of people? ACCL believes that it is important to offer courses in human sexuality, education for childbirth, and responsible parenthood. But we encourage educators to move out of the experimental phase of sex education and family life curriculum development, and assess what effects have resulted from what has been already done. If it is necessary to develop new approaches, let us work to do so. Much federal money has been spent on development of sex education materials, and we are sure that you are aware, Senator Bayh, that there are many dissatisfied parents who object strenuously to some of the course material. The concerns of those parents should not be ignored. Most parents would approve programs which encourage responsible sexual behavior and attitudes.

Many studies have shown that teenagers at risk continue not to use contraceptives or other family planning methods despite education regarding their use. In a nationwide survey undertaken in 1971[10] four-fifths of sexually experienced never-married young women aged 15 to 19 indicated that they had engaged in sexual intercourse without using contraception. About three in ten of those in that survey who reported premarital sexual experience became pregnant out of wedlock.

Clearly, mere knowledge of "the facts" is not enough to prevent unintended pregnancy. ACCL believes that education that emphasizes an understanding of the awesome responsibility of parenthood, coupled with sex education reflecting the moral and religious mores of the community and school in which it is taught can do much to reduce the number of unintended pregnancies and subsequent abortions.

FAMILY PLANNING AS AN ALTERNATIVE TO ABORTION

Research into safe and effective ways to prevent unintended pregnancies can help to reduce the incidence of induced abortion. ACCL urges that a wide variety of methods be made available to enable people with varying personal beliefs to select a method which is consistent with their own system of values. We suggest that researchers avoid injecting bias into the labeling and discussion of the several family planning methods available. While the majority of people who seek to prevent pregnancy choose hormonal, chemical, or mechanical means, a growing interest has been shown by many in an improved form of the so-called "rhythm" method, now popularly referred to by its advocates as "natural family planning." We believe that it is unwise to continue to classify all non-hormonal, non-chemical, and non-mechanical family planning methods as "folk" means, as was done in the DHEW study referred to earlier in this testimony.[11] We ask respect for the beliefs that motivate Americans to determine the size of their families, and the right to determine the method by which this is accomplished, provided that the method selected does not end a pregnancy.

IMPROVED INSURANCE COVERAGE AS AN ALTERNATIVE TO ABORTION

In many instances, medical insurance policies will pay benefits for abortions, but will not provide maternity coverage for dependent minors or unmarried women.

Single women who wish to purchase a health coverage policy which includes maternity benefits can do so, but at a much higher premium. However, abortion coverage for single women is included in most policies, without an increase in premium.

Denial of payments for maternity care based on time lapse of pregnancy after marriage or marital status is certainly discriminatory.[12]

These inequities should be corrected by legislative regulation. Lack of funds to pay for medical care, and an unwillingness to seek help by becoming a welfare recipient

are frequent reasons for seeking an abortion. Abortions are elective surgery; delivery of an infant is not. The present situation is inequitable and discriminatory and must be corrected.

IMPROVED RECORD-KEEPING OF ABORTION STATISTICS TO DETERMINE STATISTICAL TRENDS WITH PRECISION

It is essential that Congress mandate a record-keeping system pertaining to the performance of abortion and its medical and psychiatric aftereffects that would operate consistently in each state. The need for accurate, broad-based, centralized record-keeping is a legitimate part of the nation's obvious interest in maternal and infant health. There is presently very uneven and incomplete reporting of data on the demographic and statistical aspects of abortion.

The Chief of Statistical Services, Center for Disease Control (CDC) of the DHEW, Jack C. Smith, stated in January, 1975, to the United States District Court for the Eastern District of Pennsylvania:[1]

> "Abortion may have a substantial impact on the health of this country's citizens, but without complete, accurate, and detailed reporting the true impact of abortion on health will remain unknown."

ACCL believes that it is essential to set up these reporting systems and to mandate reporting by each state. Broad-based studies should also begin immediately to assess the effect of widespread abortion on family life, current attitudes toward contraceptive use, and number of unintended pregnancies conceived. We should also investigate the attitudes of Americans toward the value of human life which have developed since the United States Supreme Court decision on abortion of January 22, 1973.

A nationwide abortion reporting system can be designed to protect the anonimity of the patient. Such a system is a legitimate interest of both state and federal government and is surely related to protecting maternal health. Money is currently being spent to analyze data already available, but even those persons most directly responsible for compilation of this available data admit that it is only a sampling and is subject to criticism.[2] Conclusions regarding abortion safety, maternal and infant mortality, etc., will not be reliable unless they are drawn from accurate information. It is generally agreed by both proponents[3] and opponents of legalization of abortion that more work needs to be done in the demographic field before any solid conclusions are drawn.

ADOPTION POLICIES

Many of our national and state adoption policies need examination because they may be the source of problems for unwed or married mothers. Adoption exists to meet the needs of the child, but practices exist which negate that very basic premise and are also destructive to the mother.

It was evident from the recent Senate hearings on "black-market" adoptions that the needs and rights of children are being violated. Frightened pregnant women are being intercepted by "counseling services" which then either steer the woman toward abortion or make arrangements with second or third parties to buy the baby upon delivery.

Another example of the problems a pregnant woman may face is illustrated by the **Stanley** decision, which has been interpreted by some lower courts to mean that efforts to find and consult the putative father must be made prior to placement of a child for adoption. The attendant publicity and legal action resulting from this policy alone discourages many women from continuing a pregnancy, or from relinquishing the child for placement in a waiting qualified family.

Senator Walter Mondale's Subcommittee on Children and the Family will be holding continue hearings on the topic of abortion and foster care, which should further identify possible problems in these areas.

POLICIES AND PRACTICES OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

DHEW has recently announced that it plans to concentrate on searching out broad patterns of bias in federally funded programs and industries. In doing so, it is imperative that pregnant needy women, and those who may not be classed as economically disadvantaged but whose life situation is in crisis due to unintended pregnancy, not be ignored. Patterns of discrimination surrounding the situations of the pregnant woman are complex. Not to take up her case with vigor would be a gross injustice on the part of DHEW, and perhaps would constitute a violation of her civil rights.

The amount, type, and quality of life support assistance varies from state to state, and often varies from county to county within a state. Consequently, some few women will be adequately provided for, many will receive marginal assistance, but most are extremely disadvantaged. Often the place of residence is the sole factor determining whether pregnancy help is adequate, thus raising the question of whether women are discriminated against by their choice of geographical location.

Financial penalties are often imposed by DHEW on states which fail to notify welfare recipients and others of services funded wholly or in part by federal funds, if those services enjoy a 'high priority. Failure to notify welfare clients that family planning services are available brings a 1% fiscal penalty. Obviously, family planning can do much to prevent abortions by preventing pregnancies. However, if such services are voluntary, (and they must remain so) there will be women who will become pregnant by accident or by design and who will wish to carry their children to birth. There are no similar penalties imposed by DHEW on states who fail to fully inform pregnant women of the benefits to which they are entitled or if they fail to use all of the funds available to them to provide programs designed to meet the needs of these women. ACCL believes that notification of such services for pregnancy assistance should be made before the fact of pregnancy, just as notification for family planning is made without a requirement of evidence that sexual activity is taking place. Once caught in the panic of the crisis, it may be an overwhelming task for frightened women to attempt to find out what they may be entitled to in life supporting assistance.

Federal regulations covering distribution of services should be highlighted and the information should be made public and should be widely disseminated by the DHEW Secretary. Each state should follow suit.

SUMMARY

In this discussion we have raised a number of basic questions and have acknowledged that there are presently few readily available answers. Americans must search for those answers before we can decide whether we wish to financially support abortion, as at present, or whether a change of emphasis is indicated by factors previously overlooked.

ACCL believes that there is a heavy burden of proof upon abortion proponents to show clearly that legalization has benefitted poor and otherwise disadvantaged women. There is also need for them to show that the loss of rights of spouses, including putative fathers, and parents (rendered invalid by the United States Supreme Court) has not had a deleterious effect on the fabric of society and the structure of family life.

At the last Subcommittee hearing, Senator Bayh, you issued a directive that Dr. Philip Corfman of the National Institute of Health of DHEW assess the cost of developing more effective contraceptive methods for the purpose of reducing the number of abortions. We agree with this approach, as long as family planning continues to be on a voluntary nonpunitive basis, but it is clear that better methods of family planning are only part of the answer. There will continue to be women who conceive unintended pregnancies, no matter how perfect family planning methods become. What type of response will we offer as a nation when these pregnancies occur? Shall we as a people solve our desperate human problems with wholesale government funded abortion? Or will we choose a more humane and positive policy and combine solid legal protection for each human life with a responsible exercise of reproductive powers and a vigorous and helping response to women who become unintentionally pregnant?

We realize that some people feel that abortion should be available as one of the options offered in multi-service facilities, and that some agencies that care about women and children are already providing the variety of services ACCL suggests. The fact is, Mr. Chairman, that in our country attention is presently focused on providing abortion, and not on supplying services needed to support a woman through a pregnancy. Our adoption agencies, child welfare agencies, the National Council on Illegitimacy, the Florence Crittendon Homes, and other specialized agencies are merged, dead, or dying for lack of funds and lack of attention.

There is little evidence of interest by the federal government in providing for supportive services, and even in the private sector such funding is light. For instance, we might examine why so few United Funds provide money for alternative services such as adoption.

ACCL has in press a listing of the current federal and foundation funded research projects which cover the topics of parenthood, abortion and abortion research, population control, and family planning. A few of these projects appear to be dealing in a positive way with the problems of unintended pregnancy and its effects on the family and on society. However, the vast majority suggest an anti-natal emphasis on the study of family structure and fertility control. It is clear that many of the resources of this country have turned to funding the cheap, quick, and violent way out of complex human dilemmas, and in doing so they have abandoned many women and children.

We must bring together our best medical people, clergy, attorneys, sociologists, and concerned nonprofessionals to invite death and violence but which protects and enhances life. We believe that this dialogue on abortion alternatives must continue, and that the problems confronting the unwed or needy pregnant woman are complex enough to warrant a full investigation by the Senate Health Committee. Mr. Chairman, we urge you to encourage Senator Edward Kennedy to begin such an investigation as soon as possible.

ACCL pledges to work with all legislators in partnership to help establish a just society in which the legal system protects the rights of both women and children, and where healthy mothers, healthy babies, and stable family units are encouraged by the policies of the federal and state governments.

Footnotes

1. Moody and Carmen, *Abortion Counseling and Social Change* (Valley Forge: Judson Press, 1973) p. 21.
2. Carole Klein, *The Single Parent Experience* (New York: Walker & Company, 1973) p. 27.
3. Joan E. Morgenthau, M.D., "Family Life Education Augments Contraception for Adolescents," OB-GYN News, Vol. 9 No. 14, July 15, 1974, p. 29.
4. *Annual Report for 1974*, National Foundation-March of Dimes, p. 9.
5. Decision of United States Supreme Court in *Burns v. Alcala*, 1 FLR 3040, March 25, 1975.
6. Testimony of Joseph H. Reid, Executive Director, Child Welfare League of America, before the Senate Subcommittee on Children and Youth, February 28, 1975, pp. 3-9.
7. Ibid., p. 21.
8. "Post Trial Memorandum on Behalf of Defendants," *Planned Parenthood, et al. v. Emmet Fitzpatrick, et al.* Civil Action 74-2440 in the United States District Court for the Eastern District of Pennsylvania, p. 94.
9. *Pittsburgh Post Guzette*, June 5, 1975.
10. Shah, Zelnik and Kantner, "Unprotected Intercourse Among Unwed Teenagers," *Family Planning Perspectives*, Vol. 7 No. 1, Jan./Feb. 1975.
11. Ibid., p. 43.
12. Eunice Kennedy Shriver, *"In Support of Life"* (Minneapolis: ACCL Life Concerns Educational Series, 1975).
13. "Post Trial Memorandum on Behalf of Defendants," supra, p. 158.
14. Deposition of Dr. Christopher Tietze, as quoted in "Post Trial Memorandum on Behalf of Defendants," supra, p. 79.
15. Tietze and Dawson, "Induced Abortion: A Factbook," *Reports on Population/Family Planning No. 14* (New York: The Population Council, December 1973) p. 39.

STATEMENT ON COMMUNITY SUPPORT for The National School Age Mother and Child Health Act of 1975 and The Life Support Centers Act of 1975

I welcome the opportunity to testify in favor of the bills being heard here today (S.2360 and S.2538) because I am concerned about the problems of adolescent women and children. As an involved citizen, I have looked at the statistics showing the rising number of adolescent pregnancies. I have become acquainted with the problems of pregnant young women in my own community and in others, and I have talked with health professionals and counselors who are trying to meet their many and varied needs. In the process, I have seen that increased programs of medical care and social services were needed at the federal, state and local levels and have worked actively to initiate and promote such services.

It is my judgment, and that of the professionals in the field with whom I have consulted, that the passage of either of the bills before us today would make a significant improvement in the services available to young pregnant women and their children.

I serve as President of American Citizens Concerned for Life, a national organization actively involved in this area. One of our priorities is the restoration of legal protection for the unborn and the safeguarding of the rights of other vulnerable members of the human family. We are also involved in attempting to deal with significant problems that are present in the lives of many distressed individuals and those that they depend on for their well being. "Respect — Enhance — Cherish Human Life" is the motto which we have adopted and which accurately reflects the spirit and purpose of this organization. In addition to advocating their right to life, we in ACCL feel that society must accept responsibility for the subsequent quality of the lives of unborn children. Maintaining the quality of a child's life after birth is of as much concern to us as is restoring legal protection of life before birth.

Abortion in our eyes really involves two issues — one of justice and rights, and one of loving and caring. It is around the second issue that much cooperation and progress can occur, while the first still remains a focus of debate and division. We in ACCL do not feel that the rights of women should include the freedom to choose to destroy their unborn children, so we have worked for laws to correct the present injustice we believe is present. A widespread consensus does not yet exist on that point in this country. But people who disagree about the relative rights of the mother, the unborn child and society usually can agree that abortion is generally not a good thing and should be avoided whenever possible. Many proponents of "freedom of choice" allege that they are basically opposed to abortion. They believe that the woman's **decision** to abort is not wrong but they may still see abortion **itself** as undesirable. It should be expected that most "freedom of choice" advocates would actively support the bills before us today.

This will be particularly true when it is made clear that many poor women, pressed by financial circumstances, presently have only the "freedom" to abort and that for women of limited means abortion us far more accessible than medical assistance, financial aid and a supportive and caring environment. Surely, advocacy of the "right of a woman to choose" does include the right for her to choose to continue the pregnancy, and give her baby a chance to continue life. In the process she should be able to maintain her own self-respect, dignity and psysiological and psychological health. Programs like those under consideration today must be implemented if women are to have such a choice available. If this is not done, then in the words of a famous Janis Joplin song, "freedom is just another word." Abortion proponents have an opportunity by actively supporting these bills and other similar programs to insure that freedom is **not** just an empty word for the troubled pregnant women of this country.

For detailed information about the lack of alternatives to abortion and the need for developing alternatives to abortion, I refer you to our previous testimony presented before Senator Bayh's Judiciary Subcommittee on Constitutional Amendments. I am requesting that that testimony be entered into the record of this hearing. I would also refer you to the remarks that Senator Kennedy and Senator Bayh made accompanying introduction of their supportive services bills.

Proponents of legal protection for the unborn easily should be able to support these bills also. Their concern for the life of the unborn child surely includes advocacy of programs promoting the well-being and health of the child in-utero. Pro-life people know that the mother's needs must be given every consideration if they are truly concerned for the health and well-being of the unborn infant. It is she who is the baby's first and only line of defense. It is on her that the unborn child depends for nutrition, warmth, shelter, physiological and psychological support and life itself. To be consistent, a pro-life philosophy needs to provide protection for and enhancement of a baby's life after birth no less than before birth. It should extend to the troubled pregnant mother, the father and the family facing the crisis.

It should also be apparent to pro-life groups and individuals that passage of these bills will result in the saving of many unborn lives. One of my friends in Minnesota, who heads an active Birthright emergency pregnancy service, explained to me that most of their clients come in seeking abortion, but after finding that supportive services are available nearly all of them elect to continue the pregnancy. Many of these young women looking for a solution to their problem really wanted something other than abortion and readily chose other options when they were offered. It is intolerable that uninformed, frightened young women are being aborted because they don't know where else to turn for help.

Senator, you no doubt are very proud of your sister, Eunice Shriver, and the leadership she has shown in developing alternatives to abortion. Her challenge,

"Instead of destroying life, let us destroy the conditions that make life intolerable," should find acceptance by people on both sides of the abortion issue. We in the pro-life movement welcome her challenge to help make life more tolerable for pregnant women and children. Our neglect and apathy must not contribute to the tragedy of abortion. Support for S.2360 and S.2538 will give us an opportunity to demonstrate our consistent concern for human life.

Many other interested groups have seen the need for the types of services these bills authorize. On March 2, 1973, the National Council of Churches released a study paper on abortion containing a section on "The Churches' Responsibilities" that stated the following:

> " . . . Although diversity about abortion remains, surely it can be agreed that it is imperative to end the need for abortion. Abortion is never a desirable solution, though it is often at present regarded by some as a necessary one. Therefore, the churches are called to act as advocates for the development of public policies which contribute to a climate in which a valid choice can be made.
>
> Alternatives to abortion must be real if freedom of conscience and responsibility are to be more than rehtoric. This means that society must offer good health care, both pre and post-natal; day care facilities; homemaker services where needed; maternity and paternity leave; family service centers; and expert counseling services . . .
>
> . . . Basic to the entire subject of abortion is a reorientation of priorities to those which are life enhancing. The agony of private and social decisions regarding abortion can be eliminated as alternatives become real. It is toward this end that the churches must work . . . "

The February 13, 1973, Pastoral Message of the Administrative Committee of the National Conference of Catholic Bishops stated that: ". . . We praise the efforts of Pro-Life Groups and many other concerned Americans and encourage them to:

A. Offer positive alternatives to abortion for distressed pregnant women. . . ."

The Continental Congress on the Family, a national conference of 1800 evangelical Christians that met in St. Louis the week of October 13, 1975, issued an "Affirmation on the Family" that contained the following statement supporting programs of alternatives to abortion:

> "We acknowledge that Christians differ in their view concerning the time when personhood begins, but we agree that God has admonished us to choose life instead of death, and has set penalties for those who would, even accidentally, cause a pregnant woman to be injured in such a way that an unborn child is harmed. We believe that compassion for distressed mothers and families and concern for unborn children require us to offer spiritual guidance and material solace consistent with the teachings of God's Word. We encourage the church to influence the social-moral climate in which unintended pregnancies occur. We see no grounds on which Christians who are concerned for all human life and for the well-being of the family can condone the free and easy practice of abortion as it now exists in our society. At the same time, we exhort the church to show compassion for those who suffer because of the abortion experience."

On June 5, 1975, the Minnesota United Methodist Annual Conference petitioned the 1976 General Conference to modify the statement on abortion in the Social Principles of the United Methodist Church to provide that:

> ". . . Our belief in the sanctity of unborn life makes us reluctant to approve abortion. But we are equally bound to respect the sacredness of the life and well-being of the mother. . . . A decision concerning abortion should be made only after thorough and thoughtful consideration by the parties involved, with medical and pastoral counsel. Mothers and fathers confronted with unplanned and unwanted pregnancies are urged to seek creative positive alternatives to abortion. Moreover, the United Methodist Church supports responsible family planning and sex education, increased counseling services for distressed mothers and fathers in the event of unplanned pregnancies, improved adoption procedures, more research into genetic defects, and generally, an ethical stance which seeks solutions that are life-enhancing for mothers, fathers, and their unborn children."

There is reason to expect that other church bodies and their members will readily support and welcome legislation of the type being considered today.

Bills providing alternatives to abortion have been passed in a number of state legislatures, indicating constituent interest in services in these areas. For example, this year the Maine State Legislature passed a bill requiring health insurance plans to provide maternity benefits regardless of marital status. The Minnesota State Legislature has enacted similar legislation, along with laws extending Aid to Families with Dependent Children (AFDC) coverage to an unemployed pregnant woman prior to the birth of her child, requiring vaccinations to prevent birth defects from rubella infections during pregnancy, requiring health insurance coverage for newborn infants from birth and providing state income tax deductions for adoption expenses and state subsidies for adoption of handicapped children. Other legislative proposals have included elimination of the "illegitimate" designation on birth certificates, maternal and child nutritional food supplements, child abuse prevention programs and the creation of a commission to study family social services.

In Minnesota, a statewide Women's Political Caucus convention passed a Resolution endorsing alternatives to abortion. Both major political parties in Minnesota have also endorsed this concept at various levels and in 1972 the Republican National Convention Platform Committee heard testimony on the need for supportive services for pregnant women as an alternative to abortion.

Citizens who have seen the unmet needs of pregnant women have organized themselves to provide "hot line" crisis help to pregnant women through a large and growing number of groups known as Birthright, Alternatives to Abortion, Inc., Emergency Pregnancy Service, Lifeline, and the like. There are over 800 such groups affiliated with one national organization alone. For most of these volunteers, who have given countless hours to assist troubled pregnant women, it is a matter of deep concern that coordinated adequate pregnancy services are often not available. Most emergency pregnancy service workers should be in favor of these bills.

I would also expect that innumerable other groups who are concerned abuot the welfare of young children, the integrity of the family or the advancement of women will be supportive of this legislation.

There is great need for the additional services provided by the School-Age Mother & Child Health Act of 1975 and the Life Support Centers Act of 1975. In the minds of most of the public, preventing adolescent pregnancy would be far preferable to treatment following its occurrence. Once a very young woman is pregnant there really are no "good" choices. All of them carry the possibility of emotional and/or physiological scars for both mother and child. New efforts must be launched to find ways to reverse the trend of increasing teenage pregnancy. Provision of contraceptives to young children is not an adequate answer to the problem even though that may minimize conceptions which would result in still further problems. The promotion of responsible sexuality and parenthood and a stable family unit must be given a high priority if we wish to turn the tide. These bills would allow for such programs and include the counseling, family planning and the personal attention that would hopefully reduce recidivism. ACCL believes that family planning methods appropriate to people of differing backgrounds and beliefs should be available to those who choose to use them, provided that these methods do not end a pregnancy already begun.

ACCL's August 21, 1974, testimony before Senator Birch Bayh's Senate Judiciary Subcommittee on Constitutional Amendments contained our pledge to work as partners with Congress in building an America in which abortion is not necessary to meet the social, psychological or medical needs of pregnant women. Our later testimony before that same subcommittee elaborated on those needs and called upon Senator Bayh to urge hearings on these topics before this subcommittee. Subsequently, the bills being considered today were introduced and these hearings were scheduled.

Clearly, Senator Kennedy, the leadership you and Senator Bayh have shown in choosing to author and to advocate the passage of these bills could make a positive difference in many lives. So many people have been touched by the crisis of adolescent pregnancy that there is scarcely anyone unfamiliar with its potential tragedy and heartache. S. 2360 and S. 2538 offer a ray of hope to people across this country that we are willing to face these problems openly and realistically and to dedicate some of our resources to their solution. Fiscal responsibility does require prudent spending of the resources we have available and I believe that the modest funding necessary for these proposals is an investment in our nation's future that we can ill afford to reject.

We ask the country and the Congress to rally around and support the bills before us, putting our differences aside, knowing that the women and children of this country desperately need our help.

In this year of the woman, with its focus on women's rights, let it not be said that we turned our backs on those thousands of young women who want to live up to the responsibilities a pregnancy entails — those who will not reject their unborn child but who struggle against great odds to give the life entrusted to them a chance.

TESTIMONY ON THE ADOLESCENT HEALTH SERVICES AND PREGNANCY PREVENTION AND CARE ACT OF 1978

By

SAMUEL R. KNOX, National Program Director

American Social Health Association

I am Samuel R. Knox, National Program Director of the American Social Health Association, a nonprofit national voluntary health organization founded in 1912, and singularly focused on the prevention, control, research and eventual elimination of epidemic venereal disease in the United States.

Through a combined program of intramural and extramural activities, the American Social Health Association directly engages in biomedical research, behavioral research, educational materials development, policy analysis, professional training, the conduct of pilot demonstration projects and public awareness programming, respecting venereal disease.

Throughout the continuous sixty-six year history of the American Social Health Association, the teenager (adolescent, aged 15-19 years) has been prominently featured with regard to all of our research and program efforts. One can hardly contemplate engaging in venereal disease prevention and control without affording special attention to teenagers, in that their role and representation in the nationwide VD epidemic is enormous, as are their needs.

> We urge that any legislative initiative or program effort that focuses on the adolescent, particularly the female adolescent and her unique and particular health needs, be they pregnancy prevention and family planning or pregnancy-related services, prominently and equally focus major attention and directly address their related and

32-704 O - 78 - 10

inextricably interlocked health needs of venereal disease prevention and venereal disease-related clinical and counseling services. For, to the extent unintended pregnancy is epidemic among female adolescents, venereal disease is pandemic among this group. To the extent adolescent pregnancy represents a health threat to mother and neonate alike, venereal disease represents a mortal threat to mother and neonate alike. As alarming and compelling as the adolescent pregnancy statistics are, the female adolescent venereal disease incidence statistics are far worse – both in terms of sheer magnitude, and also in terms of severity of resulting consequences.

Unintended pregnancy and venereal disease are more than simply correlated phenomena within this subgroup of female adolescents, they are coequal major health issues born of the same set of social, psychological, behavioral, and to an extent, system deficiences. To address one and not the other is ludicrous. To attempt to divorce one from the other is artifical. To opt or consider to do anything other than approach these two major health needs of female adolescents equally and simultaneously is poor public health policy. To the extent that you recognize and acknowledge adolescent pregnancy as a serious problem deserving of your attention, you must now recognize and acknowledge adolescent venereal disease - particularly among females, as a similar, most serious problem, most deserving of your attention.

The unfortunate facts with respect to venereal disease among adolescents between the ages of 15 and 19 are statistically summarized as follows:

Total adolescents (both sexes) aged 15 to 19 years number 21 million. Total female adolescents aged 15 to 19 years number 10.3 million.

Total persons (both sexes) aged 15 to 49 years (interval of peak sexual activity) number 107,819,000.

Total females aged 15 to 49 years (interval of peak sexual activity) number 54,076,000.

Venereal disease incidence among adolescents (both sexes) aged 15 to 19 years is estimated to total over 2,500,000 cases annually.

Venereal disease incidence among female adolescents aged 15 to 19 years is estimated to total over 1,900,000 cases annually.

Venereal disease incidence among females aged 15 to 49 years (interval of peak sexual activity) is estimated to total over 5,000,000 cases annually.

Venereal disease incidence among persons (both sexes) aged 15 to 49 years (interval of peak sexual activity) is estimated to total over 10,000,000 cases annually.

On the basis of the above, the following observations and statistical inferences are made:

- Adolescents (both sexes) aged 15 to 19 years represent 19.48 per cent of all persons aged 15 to 49 years, i. e. one in every 5.13 persons aged 15 to 49 years is an adolescent aged 15 to 19 years.

- Venereal disease incidence among adolescents (both sexes) aged 15 to 19 years represents 25 per cent of venereal disease incidence among all persons aged 15 to 49 years.

- Venereal disease strikes nearly 12 per cent of all adolescents aged 15 to 19 years, i. e. one in every 8.4 adolescents aged 15 to 19 years is stricken with venereal disease.

Regarding Females Specifically

- Female adolescents aged 15 to 19 years represent 19.05 per cent of all females aged 15 to 49 years, i. e. one in every 5.25 females is an adolescent aged 15 to 19 years.

- Venereal disease incidence among female adolescents aged 15 to 19 years represents over 38.0 per cent of venereal disease incidence among females aged 15 to 49 years, i..e. one in every 257 female venereal disease cases is a female adolescent aged 15 to 19 years.

- Venereal disease strikes over 18.5 per cent of female adolescents aged 15 to 19 years, i. e. one in every 5.39 female adolescents aged 15 to 19 years is stricken with venereal disease.

To say that venereal disease reigns as an epidemic among adolescents aged 15 to 19 years is an understatement, and a gross understatement with respect to female adolescents. With case rates of nearly one in five, venereal disease is virtually pandemic within the subpopulation of female adolescents in the United States, and represents one of, if not the principal health threats to female adolescents.

Going beyond the frank and grim reality of this intolerable level of primary venereal disease incidence, one must bear in mind that women and their offspring are the main victims of the consequences of primary venereal disease incidence - the complicated and often irreversible episodes of reproductive (tubal) disfunction resulting from gonococcal and chlamydial pelvic inflammatory disease (P.I.D.) and salpingitis (which themselves are life-threatening infections), the greatly elevated risk of cervical cancer posed by infection with the genital herpesvirus (HSV-2) (presently there is no cure for genital herpes infection) and repeated infection with the trichomonas vaginalis, congenital infection of the developing fetus with the treponema pallidum, the causative agent of syphilis, neonatal infection of the emerging infant with the genital herpesvirus and the group B streptococcus (both venereally acquired by the mother) and both most often resulting in neonatal death or severe neurological and neurosensory damage to the surviving infants, transplacental infection of the developing fetus with the cytomegalovirus (a sexually transmissible virus) resulting in more infant mental retardation than even the rubella virus.

These harsh facts, unpleasant and tragic as they are, must not be swept under the rug. We must confront these realities. We must seize every opportunity to intervene on these pathological processes. We must candidly acknowledge that these female adolescents, young, inexperienced, unsophisticated, ill-informed, under-informed — often uninformed, frightened by the prospect of venereal disease vis a vis their peers, parents, and authority figures of various kinds - and often paralysed by such fear — are ill-equiped to successfully negotiate a medical system oriented toward adults, and hence slip through the cracks far too often and tragically, disproportionately fall victim to the ravages of venereal disease.

Bearing all of this in mind, it is incumbent upon us as humane, foresighted and reasonable people to prominently and forthrightly feature veneral disease as a major policy and program element of any targeted focus on the health services needs of adolescents - particularly female adolescents.

It furthermore makes good sense in all regards to approach the two major health problems facing adolescents women - venereal disease and pregnancy -collectively. First of all, the subpopulations of adolescent women with venereal disease and adolescent women who are, have been or will be pregnant are nearly the same subpopulation. The degree of subpopulation overlap is tremendous. Built upon that perception is the clinical and educational opportunity of mediating both health concerns together — "piggy-backing" one onto the other, or vice verse, which is of enormous cost effectiveness as well. Also, the dangers venereal disease pose to developing fetuses and emerging infants at parturition render the site and setting for adolescent pre- and perinatal care ideally suited for practicing primary prevention of venerally acquired, maternally imparted neonatal morbidity and mortality factors - with enormous human and economic benefits to all of society.

The Federal government expends nearly half a billion dollars annually on family planning and pregnancy related services -- and yet, despite the efforts supported by this expenditure, an estimated 510,000 unintended adolescent pregnancies occurred. Clearly this target group is being missed — and any initiatives to focus on this group are just as clearly in order.

By the same token, the Federal government expends $32 million annually for venereal disease prevention and control programs -- and *yet, despite the efforts supported* by this expenditure, female adolescent venereal disease incidence is estimated to total over 1,900,000 cases annually. There too, clearly, this target group is being missed - and any initiatives that would focus on this group are very much in order.

To focus on either major health problem -- adolescent pregnancy or adolescent venereal disease (female primarily) -- without prominently, forthrightly and simultaneously addressing the other is not sound from a policy viewpoint, health services delivery viewpoint and cost effectiveness viewpoint.

The only reasonable and prudent course of action is to focus attention on this subgroup of adolescent women, recognizing that unintended pregnancy and venereal disease represent their two most important, and woefully underserved health concerns, and address the two with equal candor, dispatch and urgency, and by so doing, in the most cost effective and ultimately beneficial manner.

1346 Connecticut Avenue N.W. Washington, D.C. 20036 (202) 785-0100

Statement

COMMENTS ON H.R. 12146, THE "ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION AND CARE ACT OF 1978"

Peters D. Willson
Political Representative

Interstate and Foreign Commerce Subcommittee on Health and the Environment
U.S. House of Representatives

June 28, 1978

Good afternoon. I am Peters Willson, political representative for Zero Population Growth, Inc. On behalf of ZPG I would like to thank you for the opportunity to testify on H.R. 12146, the Administration's proposed "Adolescent Health, Services, and Pregnancy Prevention and Care Act."

ZPG is a private, non-profit organization of citizens around the country who believe the U.S. would benefit - socially, environmentally, and economically- from a planned, voluntary end to continued population growth. In our advocacy of the importance of family planning and the availability of voluntary contraceptive services, we have repeatedly called attention to the comparatively high rates of adolescent fertility and the serious health, educational, and economic problems associated with adolescent parenthood.

These problems have been well documented in research, publications, and testimony to Congressional committees in recent years.[1] We commend both the Administration for its early efforts to respond to these problems with its own legislative proposals and this Subcommittee for taking time in its already busy summer schedule to hear testimony on this legislation.

ZPG believes it is the adequacy of H.R. 12146, not the problem of adole-

scent pregnancy itself nor the need for legislation, which is the critical issue facing the Subcommittee. "Is H.R. 12146 a sufficiently constructive and clearly defined legislative response to the problem of adolescent pregnancy?" We believe it is not and should be revised.

Inadequacies of H.R. 12146

The bill is vague in defining its relationship to existing federal programs, the population it seeks to serve, the objectives it seeks to achieve, and the priorities it sets for funding:

1. Relationship to other programs. Although the Administration has emphasized the importance of linkage and coordination of programs, H.R. 12146 does not define its relationship to existing federal programs which provide support for services to adolescents or have the potential for service support.

2. Target population. The bill seeks to serve, without making any distinction among them, not only an enormous population - 21 million teenagers ages 15 to 19 and 40 million ages 10 to 19 - but also an enormously diverse population: girls and boys; sexually experienced and sexually inexperienced individuals; youth who are still children and others who are really adults; and pregnant girls and young parents, some with more than one child.

3. Objectives. The bill establishes no more measurable objectives for HEW than pregnancy prevention, care for pregnant adolescents, and help for adolescents to become "productive independent contributors to family and community life."

4. Funding priorities. The bill offers support for a broad range of services which are often expensive to provide and do not exist in many communities.[2] Yet, it sets as priorities for funding only comprehensiveness, coordination, and service support in communities with a high incidence of adolescent pregnancy and low incomes.

As a result of its vagueness - its all-encompassing scope - H.R. 12146 would give HEW inadequate direction for the use of the limited resources it would authorize. The estimated costs of the services that would be eligible for funding only emphasize the inadequacy of direction for resource allocation.

For example, the costs of serving already pregnant teenagers alone would be considerable. Of the one million girls ages 15-19 who are estimated to become pregnant annually, 600,000 give birth and close to 90 percent keep their infants. According to HEW Secretary Joseph Califano in oral testimony to

the Senate Human Resources Committee on June 14, the costs of services per pregnant adolescent girl under this bill are estimated to be an average of $750. This does not include the costs of the infant's delivery.

According to Dr. Janet Hardy, Director of the Johns Hopkins University Center for School-Age Mothers (cited by HEW as a model program) in oral comments to the House Select Committee on Population on March 2, the estimated annual cost of comprehensive services per pregnant girl under her program is $2000, not including Medicaid/Medicare coverage for obstetrical services. Long term provision of a complete range of services for mother and child might cost an estimated $5000 annually.

In other words, if HEW were to seek only to provide services for the 600,000 pregnant girls who deliver annually, the costs might range from $450 million to $3 billion just using these estimates. Clearly, both the $60 million proposed under H.R. 12146 and the $340 million HEW has requested for its entire package of adolescent pregnancy initiatives in fiscal 1979[3] fall far short. In ZPG's opinion, the bill does not give HEW either specific objectives or sufficient priorities to guide the use of the proposed funding.

Importance of Title X

The focus of the bill should be determined both by complementary federal programs already in place and the language of the legislation itself. We believe it is no longer useful to evaluate this need for direction in the context of the Administration's $340 million budget request. One must also consider the changes Congress already has begun to make in that request.

Both the full Senate and the Interstate and Foreign Commerce Committee in the House have recommended substantial and long-term increases in funding under Title X of the Public Health Service Act, the major single source of federal funding for family planning services,[4] with a special emphasis on serving teenagers. In the history of Title X, these actions represent steps toward a

major new commitment to the voluntary prevention of unwanted births - a commitment family planning supporters have advocated for several years.

ZPG specifically endorses the funding levels and range of Title X services approved by the Senate in S. 2252, which includes earmarked funding for programs serving adolescents. The wisdom of such an escalated federal investment in the prevention of adolescent pregnancies is borne out by the most recently published analyses of data on adolescent contraceptive use and premarital pregnancy.

Looking at nationwide survey data collected in 1976, researchers in the Department of Population Dynamics at Johns Hopkins University found a "strong negative correlation between contraceptive use and continuity of use and (adolescent) pregnancy: Fifty-eight percent of never users experienced a premarital pregnancy, compared to 24 percent of sometimes users and only 11 percent of always users."[5] Today, of the estimated four million sexually active teenage girls ages 15 to 19, more than a million and a half still do not have access to medically prescribed contraceptive services.[6]

In responding to the problem of adolescent pregnancy, Congress should adopt the Title X provisions of S. 2252 and revise H.R. 12146 to build on this commitment to family planning services and education for all, including adolescents. H.R. 12146 should be revised clearly to begin to support more comprehensive services to meet the problems of pregnant adolescents and adolescent parents, who often experience additional and repeated unwanted pregnancies.[7] According to current research, a quarter of teenage mothers, including married girls, experience a second pregnancy within one year of their first birth.[8]

Recommended Revisions in H.R. 12146

Four general changes in the bill would give it the direction its needs for such a goal - a goal which we believe is already inherent in HEW's initiatives:

1. Relationship to Title X. The "Findings and Purposes" section should be rewritten to state explicitly Congress' commitment to supporting family planning services under Title X of the Public Health Service Act and its intention that adolescent pregnancy should build on, not duplicate that program's efforts.[9]

2. Target population and objectives. While recognizing the number and variety of adolescents in need of different kinds of services, this bill should specify as its target population adolescents who are pregnant, adolescent parents, and their personal friends or relatives. As its objectives in serving those adolescents, the bill should seek to improve their options about pregnancy and childbirth, improve their health and their children's health, reduce the likelihood of repeat unwanted pregnancies, and improve their chances of completing their schooling and becoming self-supporting.[10]

3. Priorities for services. The bill should require applicants for funding to demonstrate the availability of a minimum core of services for early pregnancy detection, pregnancy options counseling, pre- and postnatal health care, and family planning counseling and services in order to qualify for a broader range of educational, social, and economic services.[11]

4. Evaluation funding. Because of the dearth of research on the effectiveness of programs dealing with adolescent pregnancy, the bill in Sec. 201(c) should provide three percent of the funding instead of one percent for evaluation. In the report accompanying its approved bill, the Subcommittee should spell out its expectations for evaluation of nationwide trends, duplication of model programs, and innovative or experimental projects.

If the bill were given the clearly defined objectives and priorities these kinds of changes would accomplish, we believe it would be appropriate for the Subcommittee then to consider additional refining amendments which would further strengthen the bill.

1. Funding levels. Adolescent pregnancy is an ongoing problem with long-term effects. It will require an equally long-term response which should be demonstrated by earmarking funding for the second and third years authorized by the bill. ZPG supports authorizations of at least $90 million for the second fiscal year and $120 million for the third.

2. Ceiling on services funding. Studies by the National Alliance Concerned with School-Age Parents and researchers with the School of Public Health at the University of California, Berkeley, indicate that the major service problem in many communities is not lack of coordination or linkage but lack of services themselves.[12] Therefore, ZPG recommends that Sec. 102(e)'s 50 percent ceiling on funding of services be increased to 75 percent.

3. Maintenance of effort. Because of the need to build on existing resources - not only federal but also state and local - the bill should include a "maintenance of effort" requirement in a new Sec. 102(f).[13]

4. Advisory committee. Because of the complexity of the problems associated with adolescent pregnancy and the interest in encouraging innovative programs under this legislation, a new Sec. 201(a)(6) should be added to the bill to establish a multi-disciplinary advisory committee to advise HEW on rulemaking and evaluation requirements.[14]

5. Role of the DASPA. ZPG believes adolescent pregnancy is one of the most critical population problems facing HEW today. Departmental programs to respond to it should be coordinated under the Deputy Assistant Secretary for Population Affairs, a position mandated by Congress in the 1970 "Family Planning Services and Population Research Act," but temporarily eliminated as a full-time position by HEW last year. We recommend that the Subcommittee express its interest in seeing coordination of the adolescent pregnancy initiatives under the DASPA in communications with the Department and in report language.

Conclusion

In conclusion, ZPG believes the issues facing the Subcommittee are not whether there is an adolescent pregnancy problem but whether H.R. 12146 is adequate to deal with the problem; not whether comprehensive services should be provided under the bill but what is the bill's relationship to Title X of the Public Health Service Act and its funding priorities for services.

The legislative changes ZPG has proposed speak to those issues, and we have spelled them out in more detail in specific re-writings of the bill which I would be happy to share with the Subcommittee and its staff.

Thank you again for the opportunity to testify. I would be glad to try to answer any question you may have.

Footnotes

1 The research findings on the health, education, economic and social problems of adolescent pregnancy are summarized in the attached ZPG publication, "Teenage Pregnancy: A Major Problem for Minors."

2 In their study, "Services for and Needs of Pregnant Teenagers in Large Cities of the United States," (PUBLIC HEALTH REPORTS - January/February 1978), Hyman Goldstein and Helen M. Wallace of the University of California at Berkeley, found that only one in five of all pregnant adolescents needing special programs are accommodated under existing services. Janet Bell Forbush, Executive Director of the National Alliance Concerned with School-Age Parents, found in a survey of service providers around the country a "patchwork quilt" of services, which often would benefit more from their expansion than their coordination.

3 In its fiscal 1979 budget request, the Department of Health, Education and Welfare requested $338 million for new and existing programs to deal with the problems of adolescent pregnancy. It represented a $142 million increase over fiscal 1978. However, the only increase earmarked exclusively for family planning was $18 million under Title X of the Public Health Service Act. And that represented only $8 million in new monies and $10 million transferred from programs serving older women. In addition to this funding and the $60 million in new legislative authority, the Administration also requested increased monies under Medicaid and Title XX social service program reimbursements under the Social Security Act, maternal and Child health care under Title V of the SSA, community health centers, health education, and research and training.

4 H.R. 12370, the "Health Services Amendments of 1978" reported out of the House Interstate and Foreign Commerce Committee in May would increase Title X funding for family planning service project grants from $135 million in fiscal 1978 to $200 million in fiscal 1979 and additonal increases leading to $264.5 million in fiscal 1981. The report accompanying the bill emphasizes serving teenagers. On June 7, the Senate passed S. 2252, the "Voluntary Family Planning Services, Population Research, and Sudden Infant Death Syndrome Amendments of 1978." It would provide $216.5 million for project grants in fiscal 1979 increasing to $598 million in fiscal 1983. This would include $42.5 million earmarked for services for adolescents in fiscal 1979 increasing to $183 million in fiscal 1983. The Senate bill also would authorize several million dollars for education and materials which the House bill does not provide.

5 Melvin Zelnik and John Kantner of the Department of Population Dynamics of Johns Hopkins University report on "Contraceptive Patterns and Premarital Pregnancy Among Women Aged 15-19 in 1976" in the May/June issue of FAMILY PLANNING PERSPECTIVES. According to their research, six percent of sexually active women using a medical method of contraception regularly risk pregnancy, 11 percent who use some form of contraception regularly, and 58 percent who never use contraception. It is estimated that if adolescents did not now use contraception, an additional 680,000 girls would experience premarital pregnancies annually, increasing the annual total to 1.46 million.

6 According to the Alan Guttmacher Institute, the research and policy affiliate of the Planned Parenthood Federation of America, in its May 1978 report "Contraceptive Services for Adolescents: United States, Each State and County, 1975," six out of ten sexually active adolescent girls ages 15-19 did not have access to medically prescribed contraceptives in 1976. Of

the four million sexually active girls in this age range, 1.2 million received services from organized clinics and 1.2 million received services from private physicans.

7 In a study of pregnant adolescents and their classmates in Baltimore from 1968 to 1972, Frank Furstenburg of the Center for Population Research at the University of Pennsylvania, found a substantial gap between the family size expectations and the actual family size of young women who became pregnant as teenagers. On the average, adolescent mothers in this inner city study foresaw much smaller families than they later had within just five years. In his aritcle, "The Social Consequences of Teenage Parenthood," (FAMILY PLANNING PERSPECTIVES, July/August 1976), Furstenburg reported that within five years of delivery of their first child, 30 percent of the adolescent mothers in the study had become pregnant again at least twice.

8 In 1976, Furstenburg (see #7) stated that most published studies show that at least one-half of adolescent mothers experience a second pregnancy within 36 months of delivery. According to Kantner and Zelnik(see #5), based on their research, 25.6 percent of adolescent mothers, including married girls, become pregnant within one year of their first birth. Larry Bumpass of the Center for Demography and Ecology at the University of Wisconsin in "Age and Marital Status at First Birth and the Pace of Subsequent Fertility," DEMOGRAPHY, February 1978, found a significant relationship between shorter birth intervals and earlier age at first birth. In its report, "11 Million Teenagers," the Alan Guttmacher Institute stated that married women who begin childbearing before they are 18 will have families 1.3 times larger than women who begin to have children at ages 20 to 24. The younger women expect a completed family of nearly four children compared to the family size expectation of less than three children among older women.

9 ZPG recommends a new Sec. 2(a)(7) and (8) to specify the relationship of H.R. 12146 to Title X: '"(7) the Federal government has begun to provide support for family planning services for adolescents under Title X of the Public Health Service Act and to a lesser extent under Titles V, XIX, and XX of the Social Security Act; and (8) therefore, federal policy should continue and expand support for family planning services under Title X of the PHSA and Titles V, XIX, and XX under the SSA while providing support under this Act for comprehensive services for pregnant adolescents, adolescent parents and their immediate friends or relatives.

10 ZPG recommends rewriting Sec. 2(b) to read: (b) It is, therefore the purpose of this Act -

(1) to support the linkage, expansion, improvement and creation of comprehensive, community-based services for pregnant adolescents and adolescent parents:
(A) have options about pregnancy and childbirth,
(B) have improved health for themselves and their infants, and
(C) experience fewer unintended repeat pregnancies;

(2) to support, in supplement to these core services, other educational, social, and health services which will help the target population:
(A) complete schooling,
(B) improve vocational opportunities, and

(C) reduce future welfare dependence; and

(3) to support, in supplement to these core services, additional services or referral to services to assist the friends and relatives brought into programs serving pregnant adolescents and adolescent parents to prevent initial unwanted pregnancies.

(At the Johns Hopkins Center for School-Age Mothers, participants in the program are encouraged to bring friends or relatives with them to classes and counseling sessions; more than half do.)

11 ZPG's reasons for giving top priority to these services are:

a) Early pregnancy detection is essential to begin pre-natal care during the first trimester of pregnancy as well as to enable girls to consider the option of abortion when it is safest to their health. According to the Goldstein/Wallace survey of special services in large urban areas for adolescents (see #2) only 45 percent provide pregnancy testing.
b) Pregnancy options counseling should give the pregnant adolescent the objective information she needs to make a decision about the options open to her: to deliver and keep her infant; to deliver and place her infant for adoption, or to obtain an abortion. When she has information about all of these options, then the girl can make her own decision.
c) Not only pre-natal health care, but also long-term post-natal health care are associated with reduced risk of mortality and improved health for both mother and infant.
d) The Goldstein/Wallace study (see #2) found that ten other services are provided more frequently than contraception and five others are provided more frequently than sex education in special programs serving pregnant adolescents. Fifty-nine percent of the special programs reported by respondents to the survey provide contraceptive services.

12 As mentioned in #2, research indicates that shortage of services, not lack of service coordination, is the major problem in reaching adolescents.

13 ZPG recommends the addition of a "maintenance of effort" clause in a new Sec. 102(f): "These funds may not be used to replace funds currently being used either to provide direct services or to link services."

14 ZPG recommends the addition of a new Sec. 201(a)(6): "(6) appoint a multi-disciplinary advisory committee, of no more than 20 people, which shall be composed primarily of persons experienced in providing services to sexually active youth and pregnant adolescents and adolescent parents. Other advisory committee members shall come from organizations and agencies having experience in such areas as policy-making and research as well as consumer services. The functions of the advisory committee shall include, but not be limited to, a consultative role in the development of regulations and of overall evaluation criteria.

Teenage Pregnancy:

ZERO POPULATION GROWTH

A Major Problem for Minors

Teenage pregnancy has reached epidemic proportions in the United States. Each year, more than one million teenagers become pregnant. In comparison, 24,374 Americans contracted measles and 59,847 had mumps in 1975, the most recent year for which statistics are available. By the age of 20, three in 10 American women have borne at least one child.

Early childbearing poses serious health, social, and economic consequences for teenage mothers and their children. In addition to facing higher health risks both for themselves and their children, teenage mothers are often forced to leave school and to forego job training and other opportunities for economic advancement. Unmarried mothers face social disapproval, financial hardship, and difficulty in finding work and child care facilities. If they marry, teenage mothers are more likely to have unstable marriages and financial problems than others of the same age and socio-economic status. Women who have their first child in their teen years tend to have more children in quicker succession than their peers.

In the past, pregnant teenagers were pressured to get married or have their babies secretly and put them up for adoption. In addition, they were routinely expelled from school. Today teen mothers are asserting their right to an education, and special classes and programs have been started in many communities.

While older women's fertility has been declining during the past five years, teenagers aged 14 and younger have had increasing numbers of children, and the fertility rate of teens aged 15-16 has remained about the same. The proportion of U.S. births attributed to teenagers has been increasing; one in five U.S. births is to a teenager. Also, the number of out-of-wedlock births to teenagers is rising; teenagers account for half of all out-of-wedlock births in the United States. Most teenage pregnancies are unwanted, as is indicated by the fact that one in three U.S. abortions is to a teenager.

Experts attribute the epidemic of teenage pregnancies to increased sexual activity, non-use or ineffective use of contraceptives, and lack of contraceptive information and services for teenagers. More than four million teenage women aged 15-19 are sexually active and at risk of unwanted pregnancy. Only half of them are currently receiving contraceptive services. Of the estimated 420,000 to 630,000 teenage females under 15 who are sexually active, only 7 percent are receiving contraceptive services even though this age group is most vulnerable to health risks if they become pregnant.

Studies show that most teenagers seek contraceptive services after they have become sexually active; many of them come to clinics initially for pregnancy tests. Traditional sanctions against premarital sex have not kept teenagers celibate but rather appear to have contributed to the non-use and sporadic use of contraceptives as well as the tendency to select unreliable contraceptive methods.

Teenage Pregnancy—An Overview

Births to Teenagers

- Teenagers bear nearly one in five babies born in the United States; two-fifths of these births are out of wedlock and account for half the total out-of-wedlock births in the country.
- Three in 10 women aged 20 in 1975 had borne at least one child.

Pregnancy

- One in six teenage women who have premarital intercourse becomes pregnant.
- One in 10 teenage women aged 15-19 becomes pregnant each year.
- Six in 10 teenage pregnancies end in live births, nearly three in 10 are terminated by abortion, and one in 10 ends in miscarriage.
- Teenagers account for one-third of all legal abortions performed in the United States.

Health Risks

- The death rate from complications of pregnancy and childbirth is 13 percent greater for 15-19-year-olds and 60 percent greater for teenagers 14 or younger compared with women in their early 20's.
- Babies born to teenagers are two to three times more likely to die in their first year than babies born to women in their early 20's.

Contraception

- Only three in 10 sexually-active teenage women use contraception considerably.
- Among sexually-active teenage women who do not use contraceptives, seven in 10 think that they cannot become pregnant.
- The condom, withdrawal, and the Pill account for more than three-fourths of all contraceptive use among teenagers.
- Half of all sexually-active teenage women (about two million) are still not receiving family planning services from clinics or private physicians.

Teen Sexual Activity Increasing

More than half of the 21 million young people aged 15-19 are estimated to be sexually experienced—almost seven million young men and four million women. In addition, about one-fifth of the eight million 13-14-year-olds have had sex. A 1976 national survey confirmed that a growing proportion of teenagers are sexually active and that they are beginning their sexual activity at earlier ages. The study found that 35 percent of the single female teenagers had experienced intercourse in 1976 compared with 27 percent in 1971—a 30 percent increase. The proportion of sexually-experienced females rises from 18 percent at age 15 to 55 percent at age 19.

Most studies indicate that teenage sexual activity is sporadic. The 1976 study found that nearly half of the sexually experienced teenagers surveyed had not had intercourse in the month prior to the survey. The proportion of sexually experienced blacks (63%) is twice that of whites (31%); the survey found, but the rate of increase for whites from 1971 to 1976 is more than twice the rate for blacks.

Along with increasing sexual experience, teenagers are also contracting venereal diseases in growing numbers. Teenagers aged 15-19 are three times more likely to contract gonorrhea than people over 20, while the risk of syphilis is 61 percent greater for teenagers.

Many Teens Risk Pregnancy

Few teenagers begin to use contraception at the same time that they begin having sexual intercourse, and their contraceptive use is typically sporadic. A 1975 study in four cities found that almost half of the sexually-active females and nearly 70 percent of the males surveyed risked pregnancy at least once. A national survey of teenage contraceptive practice revealed that the sexually-active single teenage women who had never used contraception had increased from 17 percent in 1971 to 26 percent in 1976.

Nevertheless, the 1976 survey also found that those teenagers who do use contraceptives select more effective methods today than in 1971. The study found that nearly two-thirds (64%) of the single teenage women interviewed had used birth control at last intercourse, and one-third of them had used the Pill or IUD. Three in 10 said they "always" used contraception. The Pill was named the "most recently used" method by 47 percent of the teenage women using contraception, while 21 percent used the condom, 17 percent used withdrawal, 8 percent used foam, cream, diaphragm, or rhythm, 4 percent used douche, and 3 percent had an IUD.

Many teenagers who do not use birth control are poorly informed about the risks of pregnancy. According to a 1971 national survey, seven in 10 of the single teenage women who did not use birth control explained that they thought they had sex too infrequently or that they had intercourse at the "safe time of the month." Ironically, only 38 percent of the teenagers surveyed could identify the time of the menstrual cycle when pregnancy is most likely to occur.

Citing other reasons for contraceptive non-use, 31 percent of the respondents said that they could not obtain contraceptive services, 24 percent explained that contraceptives interfered with the pleasure or spontaneity of sex, and 13 percent mentioned moral or medical objections to contraceptives (Respondents gave more than one answer.). Nevertheless, eight out of 10 (84%) of the non-users said that they did not wish to become pregnant.

Research studies have found no evidence that the availability of abortion would weaken the motivation to use contraception. In a 1971 study, sexually-experienced teenage women were asked what they thought a young unmarried girl should do if she finds herself pregnant by a boy she does not love: only one in five chose the option of abortion.

Clinic Services for Teens Inadequate

Between 1971 and 1975, the number of teenagers on family planning clinic rosters more than doubled. Nevertheless, many teenagers are still unable to obtain clinic services and many programs fail to reach teenagers early enough. One study of 40 family planning clinics found that 94 percent of the teenage patients had had sexual intercourse before seeking contraceptive services, and 75 percent had been sexually active for at least a year. Thirty percent of the teenagers had been pregnant previously.

In 1975, there were 1.1 million teenage women enrolled in organized family planning programs, constituting 30 percent of the national clinic caseload. Nearly half of the adolescent patients had never used contraception prior to enrollment. After enrollment, 84 percent used the most effective methods—the Pill or the IUD. An additional 850,000-1,000,000 teenage women receive contraception from private physicians. However, about half of the four million sexually-active females aged 15-19 are still not receiving family planning help from any source. A meager seven percent of the sexually-active teens younger than 15 are currently receiving family planning services.

Pregnancy among Teenagers

Planned Parenthood's Alan Guttmacher Institute (AGI) estimates that each year more than one million teenagers aged 15-19 become pregnant—one in 10 of the females in this age group. In addition, 30,000 girls younger than 15 get pregnant annually. More than two-thirds of all teenage pregnancies are believed to be unintended.

Of the million pregnancies which occurred in 1974, 28 percent resulted in marital births that were conceived following marriage; 27 percent were terminated by abortion; 21 percent resulted in out-of-wedlock births; 14 percent ended in miscarriage; and 10 percent resulted in marital births that were conceived prior to marriage.

Among pregnant adolescents 14 and younger, 45 percent have abortions, about 36 percent give birth out of wedlock, and 13 percent miscarry. Only 6 percent of these young teenage pregnancies end in marital births.

Teens Have One-third of U.S. Abortions

Teenagers account for about one-third of all legal abortions—an estimated 325,000 abortions in 1975. In 1974, three in 10 teenage pregnancies were terminated by abortion. About half of all teenage abortions were obtained by 18- and 19-year-olds; 45 percent by 15-17-year-olds; and 5 percent by girls 14 and younger. Between 1972 and 1975, the abortion rate rose from 19 to 31 procedures per 1,000 women under age 20. Increased availability of abortion has slowed the rise in out-of-wedlock births which began in the late 1960's, but it has not reversed the trend.

Legal abortion is still not equally available throughout the country. Abortion services tend to be concentrated in one or two metropolitan areas in each state. The need to travel outside one's community is a hardship for young and poor women who often can't afford such a trip. The unequal distribution of abortion services is evident in the varying abortion ratios for teenagers in different states, ranging from three abortions per 1,000 live births in Mississippi to 1,300 per 1,000 births in New York. The Alan Guttmacher Institute estimates that a minimum of 125,000 teenagers were unable to obtain needed abortion services in 1975.

32-704 O - 78 - 11

Childbearing among Teenagers

In 1975, nearly one in five (19%) of all births in the United States was to a teenager—12,642 births to women under 15 and 582,238 to women aged 15-19. Fertility rates for older teenagers have fallen slightly in recent years, though not as sharply as the declines among women aged 20 and older. Births to girls younger than 14 have increased, while fertility among young women aged 14-17 has remained at approximately the same level. Between 1974 and 1975, the fertility rate for girls aged 10-14 increased by 8 percent.

The proportion of teenagers giving birth rises rapidly with age. The National Center for Health Statistics calculated that in 1975 nearly 1 percent of the 15-year-olds had had at least one child, 3 percent of the 16-year-olds, 6 percent of the 17-year-olds, 12 percent of the 18-year-olds, 20 percent of the 19-year-olds, and 30 percent of the 20-year-olds. Teenagers tend to have their children in quick succession. In 1975, nearly one-fourth (24%) of mothers aged 20 had had more than one child; 21 percent of all births to teenagers were second or higher order births.

Nearly two in five (39%) of all births to teenagers are out-of-wedlock, and the proportion of births to unmarried teens is increasing. With the decline in marital fertility there has been a corresponding increase in childbearing outside of marriage for both white and black teenagers. In 1975, one in five babies born to white teenagers and three in four babies born to black teenagers were out-of-wedlock. Over half (52%) of the out-of-wedlock births in 1975 were to teenagers—11,000 to women under 15 and 222,500 to women aged 15-19, a 5 percent increase over the previous year. Among those teenagers who give birth out of wedlock, 87 percent keep the child, 5 percent send the baby to live with others, and 8 percent give the baby up for adoption.

Teen Mothers Run Health Risk

Both the adolescent who gives birth and her infant face greater risk of death, illness, or injury than do women in their 20's. The maternal death rate is 60 percent higher for teenagers aged 14 or younger and 13 percent greater for 15-19-year-olds than for women in their early 20's. Women giving birth at ages 15-19 are twice as likely to die from hemorrhage and miscarriage and 1.5 times more likely to die from toxemia (blood poisoning) than mothers in their early 20's. The risks increase dramatically for women under 15 giving birth; they are 3.5 times more likely to die from toxemia. Although the health risks for younger teenagers are considerably higher than those for women aged 18-19, the risks generally increase with parity, so that an 18-year-old experiencing a second pregnancy may have dramatically increased health risks.

The most common complications of teenage pregnancy are toxemia, prolonged labor and iron-deficiency anemia. Poor nutrition, inadequate prenatal care, and physical immaturity contribute to the risk of complications.

Children born to teenage mothers are two to three times more likely to die in their first year than babies born to women in their 20's. About 8 percent of first babies born to girls under 15 die in their first year. The incidence of prematurity and low birth weight is higher among teenage pregnancies, increasing the risk of such conditions as epilepsy, cerebral palsy, and mental retardation.

Life Options for Young Parents

Education: Pregnancy and motherhood are the major causes of young women leaving school. Eight out of 10 women who become pregnant at 17 or younger never complete high school. Among teenage mothers 15 and younger, nine in 10 never complete high school and four in 10 fail to complete even the eighth grade. Despite legislation and court decisions upholding the right of school-age parents to education, the drop-out statistics suggest that many schools' policies and personnel may discourage pregnant students from continuing their schooling.

Employment and Economic Opportunity: Because many young mothers do not complete high school and the vast majority (79% in a New York City study) have no work experience, adolescent mothers are doubly disadvantaged in competing for jobs. Childcare responsibilities often further restrict employment opportunities. Teenage mothers are more likely to be unemployed and to receive welfare than mothers who postpone their childbearing until their 20's. The New York City study of teenage mothers found that 91 percent of the women who gave birth at ages 15-17 were unemployed a year and a half after the birth and 72 percent were receiving welfare assistance. Even 18- and 19-year-old mothers were slightly more likely than older mothers to be unemployed and two and a half times more likely to be on public assistance.

Marital Prospects: Teenage marriages are two to three times more likely to break up, compared with those who marry in their 20's. Teenage couples who marry as a result of pregnancy are more likely to be economically disadvantaged in terms of occupation, income, and assets than are couples of similar socio-economic status. Such marriages are also more vulnerable to divorce and separation. A Baltimore study of premaritally pregnant teenage couples (17 or younger) found that one-fifth of the marriages broke up within one year and nearly one-third dissolved within two years. Within six years, three in five of the couples were divorced or separated.

Family Size: Women who give birth as teenagers tend to have a larger completed family size and tend to have their children closer together. Married women who have their first child at age 17 or younger expect a completed family of four, while wives whose first birth comes at the ages of 20-24 expect fewer than three children. Women who have their first child at age 17 or younger will have 30 percent more children than women who begin childbearing at ages 20-24, and women aged 18-19 at first birth will have 10 percent larger families.

Laws Regarding Minors

During the last five years, there has been a clear trend toward liberalizing laws regarding the right of minors to consent to their own medical care. Currently, 26 states and the District of Columbia specifically affirm the right of minors to consent to contraceptive care, and all 50 states allow minors to consent to venereal disease treatment. In July 1976, the U.S. Supreme Court overruled a Missouri law which required a minor to have parental consent to obtain an abortion, thus invalidating similar laws in 26 states. Earlier in 1976, the Supreme Court ruled that Federally-funded family planning programs must serve eligible minors on their own consent.

Despite this liberal trend and despite the fact that no physician has been held liable for providing contraceptive services to minors of any age, many agencies and physicians still refuse fertility control services to minors without written parental permission.

The right of minors to purchase non-prescription contraceptives was upheld by the U.S. Supreme Court in a June 1977 decision. The Supreme Court invalidated a New York law which banned the sale of non-prescription contraceptives to persons under 16.

Teens Denied Information

Despite evidence from several studies that one of the major causes of unwanted teenage pregnancy is ignorance about human reproduction and the risk of pregnancy, young people continue to be denied the information they need to make responsible decisions related to their sexuality.

Research suggests that mass media, especially television and radio, are an important source of family planning information for teenagers. A 1974 family planning communication study found that mass media contributed more to teenagers' family planning knowledge than other sources, including parents, peers, or schools. However, the researchers' analyses of media coverage revealed that television and radio provided very little contraceptive information: television contained an average of only eight minutes of family planning-related programming in an entire month, while radio broadcast an average of 14 minutes monthly. Newspapers contained only 19 items during the month.

Contraceptive advertising on television and radio is banned by the Code Authority of the National Association of Broadcasters, thereby eliminating another potential source of information about contraceptives.

At present, only 29 states and the District of Columbia require the teaching of health education in public high schools, and only six of these states and the District mandate family life or sex education as part of the curriculum. While Louisiana is the only state which outlaws sex education altogether, both Michigan and Louisiana specifically prohibit teaching about contraception.

Many states officially "encourage" the teaching of these subjects in their education policies but allow for local options. Consequently, hundreds of school districts have ignored, restricted, or prohibited sex education.

Even where sex education is provided in schools, contraception is often not discussed. A 1970 survey of U.S. school districts revealed that only two in five sex education teachers included contraception in their curricula. Human reproduction, adolescent development, and venereal disease were the most commonly covered topics. A recent national survey of high school teachers in population-related subject areas found that only one-third taught anything about human reproduction, sexuality or abortion. Even fewer taught about birth control.

The Job to Be Done

A report submitted in 1976 to the Department of Health, Education and Welfare by Urban and Rural Systems Associates recommends that sexually-active teenagers be designated a high priority target population for family planning services and that Federal and state funding for family planning services be increased. To increase clinic attendance, the report encourages the establishment of separate teen clinics with sensitive staffs and low-cost, confidential treatment. State laws and policies which restrict teenage patients in consenting to their own contraceptive care should be modified, the report notes.

Additional recommendations for a national program to deal with the problems of adolescent childbearing were issued by the Alan Guttmacher Institute in 1976. Its recommendations include:

- Realistic sex education via school, churches, and mass media, including information about pregnancy risks, contraception, and abortion and places where teenagers can obtain health services.
- For pregnant teens, adequate pregnancy counseling with non-judgmental information on all available options, including abortion referral.
- Adequate prenatal, obstetrical and pediatric care for teenagers who carry their pregnancy to term in order to minimize the hazards of early childbearing for both mother and child.
- Educational, employment, and social services for adolescent parents and day care for their infants to help teenagers realize their educational and career goals.
- National health insurance coverage for all health services related to adolescent pregnancy and childbearing with provisions to protect the privacy of minors.
- Expansion of biomedical research to discover new, safe and effective methods of contraception more suited to the needs of young men and women.

Much more work needs to be done to educate teenagers and their parents on the problems related to teenage pregnancy and the availability of contraceptive information, counseling, and services. In addition, school authorities, social workers, and health personnel, especially physicians, must be made aware of the special needs of teenagers.

Teenage pregnancy is a complicated problem which will be with us for some time to come. Failing to act today only compounds the high human, social, and economic costs to be borne by teenage mothers, their children, and society in general.

Public Savings

Pregnancy prevention programs are highly cost-effective in saving future government expenditures to support out-of-wedlock children and their mothers. The Planned Parenthood Federation of America estimates that every dollar spent in one year on family planning saves two dollars in the following year alone and many times the original expenditure in the long-term. The California Department of Public Health calculated that if only 20 percent of eligible minors used contraceptive services and only 10 percent of teenage pregnancies were prevented, the net savings to the state would be $2.3 million in the first year.

Suggested Reading

- **11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States.** 64 pages. $2.50. Available from: The Alan Guttmacher Institute, 515 Madison Ave., New York, N.Y. 10022.
- **Adolescent Pregnancy and Childbearing: Growing Concerns for Americans.** By Wendy H. Baldwin. Population Bulletin, Vol. 31, No. 2. 36 pages. 75¢. Available from: Population Reference Bureau, 1337 Connecticut Ave. N.W., Washington, D.C. 20036.
- **Sex Education Action/Resource Bulletin.** 4 pages, free. Available from: The Population Institute, 110 Maryland Ave. N.W., Washington, D.C. 20002.
- **Sex and Birth Control: A Guide for the Young** by E. James Lieberman and Ellen Peck. 299 pages. $2.45 paper. (New York: Schocken Books, 1975.)
- **You** by Sol Gordon with Roger Conant. 142 pages. $5.95 paper. (New York: Quadrangle/The New York Times Book Co., 1975.)
- **Improving Family Planning Services for Teenagers** by Urban and Rural Systems Associates. 31 pages, free. Available from: Ms. Clara Schiffer, Office of Planning and Evaluation, Dept. of Health, Education and Welfare, South Portal Bldg., 441E, 200 Independence Ave. S.W., Washington, D.C. 20201.

Prepared by Cynthia P. Green and Kate Pottinger.

Additional copies of *Teenage Pregnancy: A Major Problem for Minors* are available from: **Zero Population Growth, 1346 Connecticut Ave. N.W., Washington, D.C. 20036.** Single copies free; 2-49 copies, 12¢ each; 50-199, 11¢ each; 200-499, 9.5¢ each; 500 or more, 8.5¢ each. For data and information sources, write to ZPG.

Zero Population Growth, Inc. is a national membership organization which advocates U.S. and world population stabilization. ZPG's lobbying and public education programs address a wide range of issues, including population growth, family size, immigration, teenage pregnancy, abortion, and national growth policy. ZPG welcomes inquiries regarding membership and provides a free publications list upon request.

August 1977

Printed on 100% Recycled Paper.

child welfare league of america, inc.

TESTIMONY
OF
CHILD WELFARE LEAGUE OF AMERICA
FLORENCE CRITTENTON DIVISION
BEFORE THE
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
AND ENVIRONMENT

JUNE 28, 1978

PRESENTED BY:

EMILY PALMER
EXECUTIVE DIRECTOR
LULA BELLE STEWART CENTER
DETROIT, MICHIGAN

STATEMENT OF THE
CHILD WELFARE LEAGUE OF AMERICA, INC.
PRESENTED TO THE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN
COMMERCE
U.S. HOUSE OF REPRESENTATIVES

JUNE 28, 1978

I am Emily Palmer, Executive Director of the Lula Belle Stewart Center in Detroit, Michigan, an agency of the Florence Crittenton Division of the Child Welfare League of America, and a fully accredited member of the Child Welfare League of America. Florence Crittenton has been serving pregnant women since 1883. The Child Welfare League was established in 1920, and is the national voluntary accrediting and standard setting organization for child welfare agencies in the U. S. It is a privately supported organization devoting its efforts completely to the improvement of care and services for children. There are nearly 400 child welfare agencies directly affiliated with the League, including representatives from all religious groups, as well as nonsectarian public and private nonprofit agencies. One hundred seventy-seven (177) of these provide services to unmarried parents.

The Florence Crittenton Association of America merged with the Child Welfare League at the beginning of 1976, establishing the Florence Crittenton Division within the Child Welfare League. The major programs of the 35 member agencies in the Florence Crittenton Division are focused on comprehensive services to pregnant adolescents and young mothers and their infants.

I come here today on behalf of the Child Welfare League in support of H.R. 12146, "The Adolescent Health Services and Pregnancy Prevention and Care Act of 1978." We commend the Department of Health, Education and Welfare for proposing a program to help this very underserved population. However, we are concerned that the bill does not sufficiently recognize the complex nature of services to pregnant adolescents and, as currently drafted, could very well result in the insufficient and haphazard provision of low quality services.

Targeting the funds to services after conception is our first concern. Lula Belle Stewart Center, in keeping with national statistics, finds that 94% of the pregnant adolescents we serve keep their babies. We would like to see that this bill with its limited funding focus on providing services to pregnant adolescents and young parents. We recognize prevention as a critical component of the continuum of services. We urge you, however, to take advantage of expanded Title X funds for prevention programs.

Pregnant adolescents and teenage parents do need a multitude of services. This group is not facing just one crisis, that of pregnancy. They are also experiencing many related decisions and life-changing problems. These young women may be from foster home backgrounds, and have a history of school, emotional and family problems. Any plan designed to "solve the problems" of adolescent teenagers must be sensitive to the numerous services needed to strengthen family life and prepare these adolescents for independent living.

H.R. 12146 addresses itself to the need for comprehensive programs and lists many essential core services. However, the list is not complete. Vital components of successful programs such as residential and

day care are not given sufficient emphasis. If young mothers are to be encouraged to stay in school, certain supportive services are critical. Teenagers cannot attend school or job training programs unless they are assured of quality day care for their children and infants. Nursery care for infants under three years is practically non-existent. The list of licensed family day care providers is sparse. Many Crittenton Centers, including ours, have developed their own on-site infant care services while parents attend groups and classes at our facilities.

Residential care is another key supportive service. Often, when a girl becomes pregnant, her family is unable to cope with the situation. Both the girl and her parents may require time apart to sort out their emotions. Some families cannot tolerate the situation and will not allow the girl to remain at home. Many foster families are unwilling to deal with the tensions that teenage pregnancy creates. Alternative living arrangements become quite important for adolescents. In Baltimore, the Johns Hopkins Center, recognizing this need, utilizes the residential services of the Crittenton Center. Following delivery, a family often expects the young mother and baby to begin independent living. Many do not want to take on the responsibilities of the new family. Grandmothers may have full-time jobs. They are not anxious to begin anew the task of child rearing. After delivery is the time when support services are most needed. Ironically, this is frequently the time when the least amount of services are available.

In the past few years, the Crittenton agencies have developed various innovative approaches to meeting this need. Some agencies provide apartment type housing for mothers and babies. We operate a program of

licensed foster homes for mothers and babies. However, these types of residential services are offered on a very limited basis and demand far exceeds the supply. Last year, we had 34 requests for this specialized foster care service, but could support only 11 placements. We also run a "crisis homes" program which locates temporary arrangements for mothers and babies following delivery. This allows the girls some breathing space to get back on their feet. We recommend that the bill be amended to require that varied residential services be provided as a component of a comprehensive center. This should include developing new facilities or supporting existing facilities for: (a) the pregnant adolescent, and (b) the mother and infant in a supportive environment for up to two years after birth.

Another needed service that H.R. 12146 fails to address is transportation. Drop-in centers are a sound concept, but in large urban and sprawling suburban and rural areas they may be inaccessible. We find that since the girls are in school during the day many of our classes need to be held in the late afternoon or evening. But Detroit covers a large geographic area, and like many cities, has never developed an adequate public transportation system. It is also not safe for girls to travel on buses in the evening hours. We operate two vehicles to provide this much needed transportation component. Although this is very taxing on our resources, we would have no consistency in program attendance if we did not offer transportation.

These varied service components that are the responsibility of an effective comprehensive center illustrate the difficulty involved in setting up new programs. Linking services in order to offer an adequate

program represents a constructive approach. However, since many of the services are currently non-existent or extremely limited, "linking" would be of little consequence. We recommend that the fifty percent limitation for services be increased to 75-services and 25-linkages. Most of the Crittenton agencies provide the services, but funding limitations prevent them from offering help to all in need. Last year, our center with its annual budget of almost $400,000 dollars served almost 600 adolescents. Lula Belle Stewart was initially set up to serve the tri-county area of Wayne, Oakland, and Macomb. In Wayne County alone 6,000 girls become pregnant every year. We are only able to work with ten percent of this population.

Demonstration projects with declining funds are not in order, particularly in the face of escalating need. What is necessary is an ongoing federal commitment to provide services to pregnant adolescents and young parents. At least $60 million must be appropriated for fiscal year 1979, no less than $90 million for fiscal year 1980, and no less than $120 million for fiscal year 1981.

In addition to funding this program permanently at higher levels, the requirement for a 70% Federal contribution and 30% local matching funds should be lowered to 90/10. The 10% should be allowed to be provided through "in kind" matching, including donated space, goods or services. This would coincide with Title X, Title XX and other family planning programs. Many communities have little local funding available for starting new programs and scarce local tax revenues are under severe pressure from competing interests. The Crittenton agency in Houston reports that private funds are extremely difficult to obtain in Texas.

Other limitations in H.R. 12146 lead us to believe that if the bill were enacted in its present form, few quality programs would be developed. The legislation lacks strong accountability provisions. If we are to have responsible agencies providing reliable and effective services, accountability is a must. H.R. 12146 enumerates an optional list of core services. If the aim of the legislation is comprehensive services in one center, or coordinated services linked together, certain critical services should be mandated to assure that these goals are achieved.

Additionally, standards must be attached to any funds provided under this legislation if federal funds are not to be used for questionable undertakings. We assure that all services offered meet high standards. For example, our center has hired a staff person who is responsible solely for licensing quality foster homes to assure that placements are successful. We recommend that language be added to the bill mandating service standards. This could be a provision stating that: "All services funded in whole or in part by this legislation shall meet appropriate federal standards and guidelines or the requirements of nationally recognized accrediting bodies for these services." Regulations could further detail such standards.

To further ensure accountability, individual evaluations for each program and overall evaluation must be mandated. We suggest setting aside 3 to 5 percent of funds for evaluation. We also feel that in H.R. 12146 the lack of specificity necessitates the establishment of an Advisory Council to work with HEW to develop necessary evaluation criteria regulations to guarantee that the comprehensive focus be maintained. The Council should include experienced service providers from

the social services, health and education fields. Additionally, we recommend that HEW's Secretary place this program under the Office of Human Development Services rather than under the Office of Population Affairs to ensure that the social services focus of the program be maintained.

The legislation recognizes the need for technical assistance to communities. We would like for this provision to be expanded to include priority assistance to existing centers so that they can expand their operations and develop linkages. There does seem to be an assumption in this bill that good intentions will create good services. We have spent hours with both Michigan and out-of-state groups working to initiate new programs or expand existing centers. In fact, we are now devoting a disproportionate amount of our time to this function. Groups will require ongoing and serious support to begin and run effective programs.

We commend the Committee for holding these hearings and recognizing the needs of pregnant adolescents and young parents. We would like to re-emphasize our concerns regarding the weak provisions and vague focus of H.R.12146. Comprehensive centers can effectively serve the pregnant adolescent and young parent. However, services must include day care and residential services, before and after delivery. A much higher percentage of the funds must be alloted to services or linkages will not develop.

Would these services be cost-effective? Program evaluations by LBSC and many of the other Florence Crittenton agencies indicate that many of the young parents we serve are assisted to return to school, enter job training or the employment market thus potentially reducing welfare

costs tremendously.

A high percentage (85% at Lula Belle Stewart Center in 1977) of babies born to adolescent parents who have been assisted by Florence Crittenton agencies to receive early and consistent pre-natal care deliver full-term normal babies thus reducing the risk of added medical and institutional costs for these children.

How can we not afford to offer services to pregnant girls and young parents?

CENTER FOR POPULATION AND FAMILY HEALTH

TESTIMONY BEFORE THE HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

WASHINGTON, D. C., JUNE 28, 1978

Mr. Chairman, members of the sub-committee, I wish to thank you for the opportunity to testify before you on the important issues relating to the bill on Adolescent Health Services and Pregnancy Prevention and Care Act of 1978. My name is Allan Rosenfield and I am Professor of Obstetrics/Gynecology and Public Health, and Director of the Center for Population and Family Health, both at the College of Physicians and Surgeons, Columbia University, New York.

As an obstetrician-gynecologist involved in a range of public health and social issues, I have been particularly concerned about the increase in sexual activity among adolescents, with a resultant increase in pregnancy rates. While there has been a slight decline in recent years in the number of births to women between the ages of 18 and 19, this decline has been much less than that which has occurred among women over the age of 20. For women 17 and under, there has actually been an increase, strikingly so, for girls under the age of fifteen. But these and related facts and figures are well known to all of you who are concerned about this issue, and I don't think it necessary to repeat this data once again.

The document prepared recently by the Alan Guttmacher Institute of New York, entitled "Eleven Million Teenagers," is familiar to you and I think cites most clearly and cogently the facts about this truely critical problem facing society in the 1970's. This is not to say that problems have not existed in the past, but now that we are acquainted with them,

and understand their serious implications, it is absolutely essential that we take appropriate steps and action.

The Columbia-Presbyterian Medical Center in New York City, a hospital which serves a predominantly low income, inner-city minority population, has developed two programs which address specifically the needs of the adolescent, which might well serve as models for national programs to be developed in the future. For several years, a committed nurse-midwife and social worker have run a program aimed at providing comprehensive care for the pregnant teenager who plans to carry the pregnancy to term. The staff provide warm and supportive care which we believe has resulted in a decline in the medical risks of teenage pregnancy. The program, however, has serious fiscal problems, since so many of the young women are poor, but not eligible for Medicaid. Our team also has established a Young Parents Program (also underfunded) which provides support during the first years of parenthood. While it is still too soon to have good data, it is our impression that the incidence of child abuse among these mothers is less than expected and more of our mothers return to school or find a job. But the social and economic obstacles facing these young women are immense, and our program is only a small part of what is needed.

More recently, the Medical Center, with assistance from DHEW, has started a Young Adult Clinic aimed specifically at reaching the sexually active teenager, whether or not she has had a previous pregnancy. Our goal, in this particular program, is to provide counseling and education about the reproductive process, about the workings of a woman's body, as well as that of her partner, and the offering of a contraceptive program for those who are interested in preventing a pregnancy. In this program,

we stress reaching the male partner as well as the female. In addition, we are working with members of the community in developing a broader educational effort aimed at school children of all ages, working with the school system of our district, as well as with the many church and social groups in our area. We feel that such education and preventive programs are crucially important to goals that are being discussed.

Through programs such as these, we believe that a large tertiary-care center is beginning to meet some of its obligations to the community to provide responsible preventive and primary care services. Such institutions must be so involved, in addition to the community or neighborhood health centers, both because of their role as teachers of future doctors, nurses and other health team members and because they have the responsibility to their communities to do so. But there are significant fiscal short-falls, particularly in terms of educational programs aimed at the teenager before she becomes pregnant, funds for pregnancy services, as well as means to cover abortion for those adolescents who choose this option, and funds to provide basic primary health care to these same adolescents.

To my mind there are four basic programs that are required for the health needs of teenagers in the United States today. The first, and one of the most important, is the development of effective information and education programs concerning the processes of human reproduction, the adverse effects of early childbearing, responsible parenthood, contraception and related issues. As the Alan Guttmacher publication on teenagers so aptly documents, there are few effective sex education programs in schools in most states in this country, and in the majority of those

schools having such programs, discussions about contraception and abortion are often omitted. Many people are concerned about the moral issues involved in the increasingly early ages at which sexual activity is initiated by adolescent boys and girls. While this is a complex and most difficult issue, I think that the changes which have taken place within our culture and society concerning sexual activity are unlikely to be reversed. If individuals are to be sexually active, it is imperative that they be responsible and understand the various possible consequences of this activity.

It is important to dispel myths existing among many teenagers as to what it is like to have a child. Somehow it is often envisioned that such a child will relieve the boredom and frustration of adolescence and, in effect, will be a toy for the teenager to take care of. The reality is, of course, far different and the incidence of child abuse is probably highest among this high-risk age group.

The second key area is the provision of preventive services for sexually active non-pregnant teenagers. This relates primarily, but not only, to contraceptive information and services. This Committee has played a critically important role in recommending new levels of Title X funding for family planning services, well beyond the amount initially proposed by the administration. Secretary Califano's press release statement of April 13, 1978 demonstrates the administration's interest in alternatives to abortion; I only hope that they will be more active in their support for the appropriate preventive services.

The third area relates to counseling and services for pregnant teenagers and their children. For those women who choose to carry the pregnancy to term, there is increasing evidence to suggest that, where

careful counseling and a full series of antenatal visits take place, the increased risk among teenagers of pregnancy to both mother and child can be decreased. We should, therefore, strongly support the expansion of existing services, at the same time attempting to remove obstacles to the care, the most significant one being the inability of many teenagers to pay for their antenatal and postpartum care. Although I realize the issue is a controversial one at the present time, services should equally be available for those teenagers who make the free choice to undergo abortion rather than carrying the pregnancy to term. There simply should not be a double standard of care between those with money and those without.

The fourth area of importance relates to the provision of primary health services to the teenager and her child, together with support for expanded day care centers (the latter allowing the teenage mother to complete school or to obtain a job). While in general this is a healthy age group, it is not at all uncommon for providers of either family planning or pregnancy services to identify health-related problems for which there is often inadequate financial support to provide the necessary care.

The bill being considered by this Committee, as presently constituted, appears to me to be extremely encompassing with inadequate funds allocated for the range of activities described. The present Title X funding, as proposed, for family planning services, including those specifically allocated for adolescent care, is already favorable. I would, at the same time, strongly urge that Title X funding, as well as funding for family planning through Title XX, be increased, so that we could more adequately meet the family planning needs of this population. I would urge, however, that the relatively small amounts of money being discussed in this bill be

allocated for the provision of better services to the pregnant teenager. I would include, within this, funds to cover the basic health needs of these same individuals. Finally, I would urge that a new bill be developed, such as the recent provision passed by the Senate, to support the critically important areas of health and sex education aimed at the adolescent. We must find ways to provide appropriately developed educational materials and information at all levels of the school system, as well as through church, social and community groups in neighborhoods of our cities and in our rural areas as well. Equally important is the need to develop a cadre of trained professionals in adolescent sexuality and behavior, for too many initiatives have floundered for lack of effective personnel to implement programs.

In this regard, I would like to relate a recent experience of ours. Although we have been providing some support for educational activities in two high schools in our district, the principals of both high schools urged us to attempt to develop some programs for the children before they enter high school; it was their impression that high school was already too late for an introduction to this topic. Through the help of a district guidance counselor, who serves on our Adolescent Community Advisory Board, a meeting was set up with fifteen principals from elementary and junior high schools in the Washington Heights district of Manhattan, together with a small number of representatives of local parent-teacher associations. After discussing our concern about this problem, we were surprised to receive the unanimous recommendation from the principals, supported by the parents, that the schools needed assistance in the development of educational programs in the area of human reproduction, beginning in kindergarten and being

carried out through the rest of the school years. The parents pointed out the need for adapting these educational efforts approximately, both in terms of the age of the students and also the different cultural backgrounds. We wish to do this in our area, but are significantly hindered by the lack of funds to develop such a program. We are seeking, at present, some funding support from private institutions and private foundations to allow us to move forward with such a program, but I strongly urge that Congress allocate significant funding to allow improved educational programs in this area.

I again wish to commend this Committee for its support for the urgently needed comprehensive preventive health and family planning programs, particularly for adolescents. We must provide this high-risk group of young people with appropriate education and services.

We live in a world whose population is growing at an alarming and unprecedented rate, a world whose limited resources are being threatened. Ours is a world where the majority of people go to bed hungry, with little hope for a better tomorrow. We live in a world where too many people, especially children, die from simple diseases that could be easily cured or prevented with relatively low-cost approaches already at our disposal. Today, simple health and family planning services are still not available to a large percentage of the populations of many countries.

Our primary goal at the Center for Population and Family Health (CPFH) is to improve this situation through our work in the broad and complex fields of population, family planning, and health care for mothers, children, and families. We are working to generate more knowledge and understanding in these fields, and to put our findings to practical use.

We hope to be able to assist in, and contribute to, efforts aimed at improving the quality of life of the world's poorest billion and to help bridge the gap between rich and poor through a combination of research, service, and teaching activities, both in the U.S. and in the developing world.

This report details the major activities of the CPFH and gives a brief description of its staff, publications, and budget.

Allan Rosenfield

Allan Rosenfield, M.D.
Director

A BRIEF OVERVIEW

In 1966, Columbia University, with a grant from the Ford Foundation, established the International Institute for the Study of Human Reproduction in response to the increasing world-wide concern about rapid population growth and its impact on humanity's future well-being.

Headquartered at Columbia's College of Physicians & Surgeons, the Institute is composed of a multidisciplinary group of scholars committed to teaching, research, and technical assistance in a wide range of areas related to the population field in the U.S., Europe, Latin America, Africa, and Asia.

In 1975, the Institute was reorganized into two semi-autonomous centers.* This one, the Center for Population and Family Health, (CPFH) is affiliated with both the School of Public Health and the Department of Obstetrics & Gynecology. Dr. Allan Rosenfield, an obstetrician-gynecologist with extensive experience in the area of health and family planning, was appointed its first director in May of that year.

CPFH focuses on the generation and application of new knowledge and the solution of the pressing problems of population and family health, both at home and overseas. It has a staff with expertise in a variety of disciplines, including medicine, public health, law, psychiatry, sociology, demography, anthropology, and economics.

Four Program Areas: CPFH has four major divisions, plus two important supporting units. Lessons and insights gained in one division inevitably influence work in the others. The overall effect is synergistic. Staff members work interchangeably among the different divisions and units to produce strengthened, multidisciplinary efforts. Among the objectives of the four divisions are the following:

1. International Research and Technical Assistance
To help developing countries to create, implement, manage, and evaluate new approaches to the delivery of family planning and maternal, child, and family health services for low-income groups in rural and urban areas. On a broader scale, to help these countries gain a better understanding of the complexity of the population, health and development problems they face, and to contribute to their policy formulations.

*The Institute's other arm, the Center for Reproductive Sciences, is concerned with basic reproductive research in such fields as endocrinology, genetics, biochemistry, and obstetrics-gynecology.

2. Community-Oriented Reproductive Health Services for Women
To develop a workable, high quality program of reproductive and sexual health care for women in the obstetrical and gynecological clinics of the Columbia-Presbyterian Medical Center, with an initial focus on adolescents, a particularly high risk group. More specifically, to make this program a community-responsive one, which emphasizes the social and emotional aspects of health care, as well as the physical, and which provides educational and counseling services both in the clinics and in the community.

3. Adolescent Social Science Research
To generate and maintain a broad and general program of research devoted to the problems of adolescent sexuality, pregnancy and contraceptive practice, with an emphasis on questions related to the delivery of services to this group.

4. Teaching
To provide courses leading to masters and doctoral degrees in Population and Family Health for students in the School of Public Health, and to introduce the social and preventive aspects of these fields to students from the other Health Science Faculties.

Support Units: *The Library Information Unit and the Statistical Unit*
Two other units support the activities of the Center's four divisions. The Library Information Unit collects and disseminates information on program development and evaluation in family planning and acts as a major worldwide source of this information through its contributions to the international POPINFORM data base in Washington. The Statistical Unit provides consultation in, and access to, statistical and computer services, both to the CPFH staff and to outside agencies.

INTERNATIONAL RESEARCH & TECHNICAL ASSISTANCE

To those governments and private associations in developing nations who request it, CPFH provides research-oriented technical assistance in developing, implementing, and evaluating new and improved approaches to family planning and related family health services. The nature and extent of the assistance depends upon the needs of the particular country and/or agency.

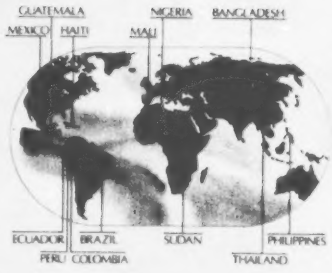
Currently, most Asian nations have official population policies and are actively involved in implementing them. Most Latin American countries have family planning programs but lack official policies. And in Africa, consciousness of population-related problems is only beginning to emerge.

Adequate health care services still do not reach—or are unavailable to—a large percentage of the world's population, particularly those living in rural and urban slum areas. Further, there is a poor balance between curative and preventive care. More appropriate and effective roles are needed for paramedical and lay personnel in the delivery of improved health care and family planning services.

Since 1975, CPFH has established research and technical assistance relationships with agencies in ten countries: six in Latin America, one in the Caribbean, and three in Asia. Plans are currently underway with institutions in several other countries in Africa and Asia. Country-by-country, CPFH is involved in the following activities:

MEXICO

CPFH's work in Mexico began in 1975, when it assisted in a study to evaluate the cultural, social and medical acceptance of the use of local traditional healers, such as spiritualists, herbalists and injectionists, to provide family planning information and services in a typical rural village. A new government was elected in 1977, and it gave very high priority to the implementation of programs aimed at reducing Mexico's high rate of population growth. CPFH was requested to assist the National Family Planning Coordination Council of Mexico in planning the overall research and evaluation strategies for the national program. Further, CPFH was asked to help the Ministry of Health's Directorate of Maternal/Child Health and Family Planning plan, implement, and evaluate programs to extend family planning and maternal/child health services throughout the rural areas of Mexico. A large scale operational study of approaches to village-based service delivery is scheduled to start in early 1978.



GUATEMALA

APROFAM, the private family planning association of Guatemala, which works closely with the Ministry of Health, requested CPFH assistance in the evaluation of its community-based contraceptive distribution programs, with the aim of improving and expanding these activities. Based on the CPFH evaluation, APROFAM is expanding these programs, working closely with agricultural cooperatives and federations of agricultural workers.

PERU

The Government of Peru recently established a population policy to permit family planning activities to be carried out as a part of maternal and child health programs. Subsequently, the Neonatal and Maternal-Child Health Institute (INPROMI) requested CPFH advisory assistance to help develop and evaluate two maternal-child health and family planning studies aimed at delivering services at the village level in rural areas. Assistance has also been requested in the development of training courses for both medical and paramedical staff of INPROMI and in the analysis of data from a large study of mothers at high risk during pregnancy.

BRAZIL

BEMFAM, the private family planning association of Brazil, has been a Latin American pioneer in the use of community volunteers to distribute contraceptives to their neighbors, particularly in rural villages. CPFH is providing assistance to BEMFAM in the establishment of a management information system to help evaluate the results of this innovative program. The first followup survey has recently been conducted, which will provide much useful information on the effectiveness of this program approach. The government of Brazil recently has increased its commitment to population related activities and has requested BEMFAM to expand its activities in support of this new policy direction. BEMFAM, in turn, has asked CPFH to assist in its expanded evaluation activities.

ECUADOR

In December 1977, CPFH terminated a long working relationship with the Evaluation Unit of the Program Development Division of the Ecuadorian Ministry of Health. A full-time CPFH statistician, resident in Quito since 1973, provided technical assistance to the Evaluation Unit in the collection and interpretation of maternal-child health and family planning service statistics. The New York staff of CPFH supported the resident advisor through periodic visits, the most recent of which was to participate in a major review of Ecuador's family planning programs. PAHO's new evaluation unit will provide assistance in the future.

COLOMBIA

The CPFH's regional Latin American representative has been stationed in Bogota, Colombia since 1976. In addition to providing assistance to the above-mentioned programs, the regional advisor has worked with the Colombian Ministry of Health, most recently helping the Ministry write rules and regulations for Ministry health providers. When implemented, they will greatly increase the importance of various non-physician personnel in providing services. He has also assisted in the preparation of training courses for physicians, nurses, and auxiliaries. Additionally, CPFH has collaborated in two studies by Profamilia, the private family planning association, comparing IUD insertion by physicians and non-physicians. More recently assistance has been requested to help evaluate the services provided by a new private clinic which provides care for women with incomplete abortions or miscarriages.

HAITI

CPFH and its predecessor unit have worked for many years with the Evaluation Division of the Haitian Ministry of Public Health. As the Division developed its own competence, the role for CPFH changed. It now focuses on assisting the Ministry in carrying out a large pilot operational research project in three rural areas of the country. The aim is to develop health and family planning service delivery approaches in a country with almost no rural health infrastructure. Because most of Haiti's population lives in rural areas, and because of the lack of services in these areas, this project is of particular importance. A resident CPFH staff member is stationed in Haiti.

THAILAND

The CPFH Director spent many years in Thailand working with a number of different governmental and private agencies. Through these contacts, a continuing CPFH relationship evolved. A staff member works full time with the National Family Planning Program and the Division of Family Health at the Ministry of Public Health. He is specifically assigned to work with the

Research and Evaluation Unit and is actively involved in a wide range of research and evaluation activities, relating primarily to the national family planning efforts. Initial attention has been given to improving the Program's management information system and to a variety of studies involving the use of various categories of paramedical personnel. CPFH also has a close relationship with the Mahidol University School of Public Health, which has an active operational research program, and with the Community-Based Family Planning Services Program, one of Asia's most innovative and creative private agencies devoted to the delivery of family planning and health information and services.

BANGLADESH

A CPFH staff member is assisting a local private agency in evaluating an important and exciting project utilizing the commercial sector to deliver contraceptive services to the people. Discussions also are presently underway for Center involvement in a new approach to the teaching of community medicine to medical students. It will focus on the current population, medical, and public health concerns in Bangladesh. If this activity does materialize, it will probably include a long term advisor. Efforts aimed at fertility reduction in Bangladesh are of critical importance to this country, perhaps more so than anywhere else in the world, and the CPFH hopes to be able to make a significant contribution here.

PHILIPPINES

Discussions are presently taking place with officials of the Population Center Foundation in Manila concerning a collaborative relationship for the development, implementation and evaluation of a number of operational studies. These will emphasize new and improved approaches to the delivery of family planning and health services to both urban and rural poor in the Philippines. As in several other large cities (e.g. Bangkok and Mexico City), we are discussing studies devoted to a better understanding of adolescent sexuality, fertility, and contraception in urban areas of the developing world.

AFRICA

CPFH staff members have been invited to visit several sub-Saharan African countries, including Kenya, Mali, the Sudan, and Nigeria. Formal discussions are underways in both Nigeria and the Sudan regarding the development of studies of new approaches to the delivery of simple primary health and family planning services to the predominantly rural populations of these two countries. Increased attention and priority will be given by CPFH to the development of such studies in this highly important continent.

COMMUNITY-ORIENTED REPRODUCTIVE HEALTH SERVICES FOR WOMEN

A natural extension of the overseas involvement of CPFH is the development and implementation of new approaches to the provision of health services for women in the United States. Situated at one of the world's leading medical institutions, CPFH has the challenge and the opportunity to produce a model program which will provide insight into the most effective and rational modes of health care delivery for women.

The Washington Heights community surrounding the Medical Center has undergone major changes during the past decade, becoming increasingly dependent on the Medical Center for primary health services. The older and more stable middle-income population, including sufficient office-based physicians, has left the area and has been replaced by a younger, low-income mobile group with various unmet health and social needs. Therefore, in conjunction with Presbyterian Hospital's Obstetrics and Gynecology Service, CPFH began planning for an extensive reorganization and expansion of ambulatory reproductive health care for women in the hospital's Vanderbilt Clinic.

A Young Adult Clinic was opened in 1977 to give specialized counseling and contraceptive services to male and female adolescents in the community. Since no such services had existed specifically for this high risk group, we hope to be able to reduce unwanted and unplanned pregnancy. Clinics are made easily accessible through late afternoon and early evening sessions. Group and individual counseling are offered with bilingual counselors available, and extensive outreach programs are being developed in the schools and with community groups. Further, an Adolescent Advisory Council composed of a broad range of professionals and community leaders has been formed to assist in the development of the program.

and to monitor its progress. Close links have been developed with a most successful, on-going program for pregnant adolescents run by midwifery and social service personnel.

In addition to improving services for women within the Obstetrics and Gynecology Service, collaborative relationships are being developed with the Departments of Medicine and Pediatrics to initiate comprehensive primary health services for the community in a responsive, cohesive manner.

To meet the varied objectives of this program, the complete renovation of the existing outmoded facility is planned. Improving patient flow, providing privacy for medical and counseling services, and increasing patient-staff interaction in an environment which would be both compatible and inviting are critical and will be dealt with in the immediate future.

Strengthening the role of the Columbia-Presbyterian Medical Center within the community through responsive services is of utmost importance, and CPFH is playing a special part in this. Equally important, as an institution that trains future leaders in medicine and health, is the opportunity for students, interns, and residents to participate in a program which emphasizes social and preventive aspects of care, as well as the provision of sympathetic personalized clinical services.

ADOLESCENT SOCIAL SCIENCE RESEARCH

One of the most pressing challenges to health care providers is the recent change in this country in sexual behavior, contraceptive use, and pregnancy among adolescents. Despite the growing availability of contraceptive services, only about one-third of sexually active, fecund teenagers are protected by contraception. At present, more than one million young women become pregnant each year. The majority of these pregnancies are unintended. As a result, some 600,000 teenagers became parents last year, and over 300,000 terminated their pregnancies in abortion. This problem has acute health and social consequences.

While less well-recognized, similar problems exist in developing countries. Rural people are migrating to the crowded urban environment at an increasingly rapid rate today, and the traditional role of the extended family is breaking down. The result is increasing rates of pregnancy and venereal disease among adolescents.

The Adolescent Social Science Research Unit has recently been created to study and respond to some of the many unanswered questions regarding adolescent sexuality, pregnancy and contraceptive use. The Unit has close relationships with both the expanded adolescent health care service at the Medical Center and the international program. Three major objectives have been identified:

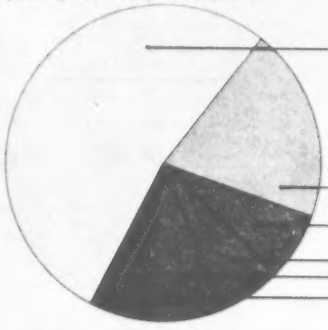
- To generate research which addresses the important and practical questions involved in delivery of clinical services to adolescents;
- To provide assistance for adolescent studies in countries which are part of the CPFH international program of technical assistance; and
- To maintain a broad and general program of research on the causes and consequences of adolescent sexuality, contraceptive use, and pregnancy behaviors.

Staffed by four persons, the Adolescent Unit reflects the inter-disciplinary orientation of CPFH as a whole. Members have training in sociology, demography, socio-medical sciences, and education. Projects currently underway or in the planning stage include:

- A Ford Foundation sponsored project to study the impact of population education on secondary school students in the United States. This project will include the creation of a simulation game on teenage contraception and pregnancy;
- A study of the quality of parenting among adolescents in cooperation with the director of Social Services for Obstetrics-Gynecology at Vanderbilt Clinic;
- Collaborative research with several other service agencies, including a study of sexually active adolescents and their partners at the Door, and a study of adolescent abortion at PRETERM in Washington, D.C.;
- Projects analyzing data on adolescents, including an analysis of interviews with mothers and their teenage children concerning communication about sex and birth control in the home;
- Development of adolescent-oriented studies in urban areas in collaboration with developing country agencies;
- Studies of the determinants of contraceptive continuation among adolescents and of the educational consequences of adolescent childbearing; and
- On-going evaluation of the Young Adult Program at Vanderbilt Clinic.

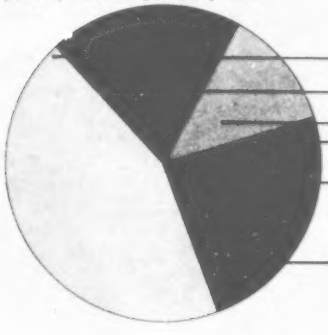
THE BUDGET

PROJECTED EXPENDITURES BY FUNCTIONAL CATEGORY
JULY 1, 1977 TO JUNE 30, 1978



Functional Category	Amount	%
I. International	$339,693	17%
Latin America	130,491	6
Asia	75,753	4
Africa		
Developing Country Subcontracts	550,000	27
Library/Information Services	99,949	5
	1,195,886	59
II. Women's Reproductive Health Care	364,670	18
III. Adolescent Social Science Research	117,767	6
IV. Teaching	117,223	6
V. Administration	131,658	7
VI. Other	82,446	4
	2,009,650	100%
Direct Costs	321,193	
Indirect Costs		
Grand Total	$2,330,843	

PROJECTED INCOME BY DONOR
JULY 1, 1977 TO JUNE 30, 1978



Donor	Amount	%
Agency for International Development	$666,567	45.7%
Health, Education and Welfare Dept.	261,982	17.9
Rockefeller Foundation	150,755	10.3
Clinic Reimbursement	99,956	6.8
Mellon Foundation	64,895	4.4
Pan American Health Organization	41,651	2.9
National Institutes of Health	36,353	2.5
Population Crisis Committee	29,572	2.0
Ford Foundation	22,088	1.5
General Services Foundation	21,901	1.5
Commonwealth Fund	21,246	1.5
School of Public Health	20,057	1.4
Population Council—ICARP	12,947	.9
Obstetrics/Gynecology Dept.	9,680	.7
Direct Costs (CPFH)	1,459,650	100.0%
Direct Costs (Developing Country Research Subcontracts*)	550,000	
Indirect Costs	321,193	
Grand Total	$2,330,843	

*Donor: Agency for International Development

TEACHING

As a Division in the School of Public Health since early 1976, CPFH offers full programs of study leading to masters and doctoral degrees. In addition, population and family health classes, courses, and seminars are available to students throughout the Columbia University family of schools and colleges.

An important feature of the CPFH academic program is its practical orientation. CPFH faculty and adjunct faculty, are not exclusively teaching faculty, but are also the professionals who are responsible for the CPFH Adolescent Social Science Research, International Research and Technical Assistance, and Women's Health Care Programs. Thus, our faculty bring to the teaching of theoretical material a wealth of first-hand current practical experience. Students are encouraged to participate in tutorials in both service delivery and research projects. For students who come with no prior professional experience, a three-month practicum or internship is required. Finally, the Center sponsors a weekly luncheon seminar series at which prominent practitioners in the field of population and family health discuss their work with students and faculty.

While the School of Public Health does not have a formal program of studies in the field of international health, it does have considerable expert resources in this area. CPFH represents the greatest concentration of these resources and provides a base for masters and doctoral students with international interests. Periodically, CPFH will provide short-term training for management and evaluation workers in overseas programs. In the past year, CPFH faculty traveled to Nairobi to conduct a one month training program in evaluation methods for research and evaluation workers of the Kenya National Family Planning Program. Also, a group of Peace Corps Volunteers spent two weeks at CPFH in preparation for health assignments in the Central African Empire.

Over the past two years the Division has introduced the concept of family health into its teaching program by adding new courses and by infusing the concept into the content of existing courses. In the future we hope to enrich our program further by introducing courses relating to adolescent health and fertility. At present, over twenty courses are offered by CPFH, and students also have the opportunity to take a wide range of relevant courses of other Divisions of the School of Public Health.

THE SENIOR STAFF

KATHERINE BLOUNT SKEET, CNM, is presently working in the clinical program. Prior to joining the CPFH, she worked as a midwife at Morrmania Hospital and has much experience in the provision of care to women in the ambulatory setting.

CHRISTINA BRINKLEY-CARTER, Ph. D. (Demography and Sociology), is Assistant Professor of Public Health and has been involved in health education manpower research and program evaluation for more than twelve years. Her major interest is in linking service with research and theory. Substantive interests are adolescent fertility and parenting, and population policy as related particularly to economic development and manpower utilization.

LANDIS K. CROCKETT, M.D., M.P.H. (Preventive Medicine), is Medical Director of the family planning and abortion clinics. His background is in community medicine, family planning, and public health. Prior to joining the Center, he helped establish and run a special program for teenagers in Ann Arbor, Michigan, and is assisting in the implementation of the Center's Young Adult Program. He also has a special interest and experience in the management of venereal disease problems.

TOVA COPELAND, M.A. (Education), has recently been recruited as the first full-time health educator working in the community surrounding the Columbia-Presbyterian Medical Center.

NICHOLAS CUNNINGHAM, M.D., Dr.P.H. (International Health), is Associate Professor of Pediatrics and Public Health. He has had extensive experience in the delivery of primary care to children, first in rural areas of Nigeria and then in New York City. He is presently Director of the Division of General Pediatrics in the Medical Center, responsible for ambulatory services for children, and is involved in CPFH international and teaching programs.

KATHERINE F. DARABI, M.A., M.S. (Health Education), is a Senior Staff Associate and a member of the Adolescent Social Science Research Unit. Her main interests are the studies of the relationship between education and fertility, and technical assistance to international projects in training and education. She has had prior experience abroad, working for IPPF/Western Hemisphere and for CARE in Ecuador. She is a Ph.D. candidate in Adult Education with a specialization in Community Development.

HENRY ELKINS, Ph.D. (Social Demography), is a Research Associate. His chief interest is in applied research in population, family planning, and community medicine. He has recently been engaged in research on social marketing and community based delivery systems in Asia and Latin America. His background includes research in Colombia, Mexico, and Bangladesh, and teaching at the University of Chicago and the Latin American Demographic Center (CELADE). He also serves as Secretary of the Liaison Office for the International Committee on Applied Research in Population.

GLORIA GREEN-CALLENDER, C.N.M., M.S. (Community Health Education), is the Family Planning Service Director and clinical instructor in Nurse Midwifery. She has had extensive experience in the area of public health and community education. Her major interest is to reach and educate young people during the pre-teen years and on through young adulthood. She is currently working toward an Ed.D. degree.

MARTIN GORISH, Dr.P.H. (International Health Administration), is Assistant Professor of Population and Family Health and Assistant Director of the CPFH for Academic Affairs. He directs the teaching program in the School of Public Health and is also responsible for short-term management-oriented training programs. He has been involved in operational research and evaluation activities in the U.S. and abroad and has had extensive experience in the U.S., Africa, Asia and Latin America with Johns Hopkins University, USAID and the National Institutes of Health.

STEPHEN ISAACS, J.D. (Law), is Assistant Professor of Public Health and Assistant Director of the CPFH for Operations. His areas of expertise encompass family planning program development, population law and policy, and development planning. Prior to joining the Center, he served as Program Director for the International Planned Parenthood Federation/Western Hemisphere Region and as a Program Officer in the Agency for International Development's Mission to Thailand. Before that, he served as an attorney in the General Counsel's Office of the Department of Health, Education, and Welfare.

PRISCILLA JENCKS, M.P.H. (Health Administration and Planning). Her special interest in adolescent health services and family planning led to her present position ans administrative coordinator of the Young Adult Program.

JUDITH JONES, B.A. (Psychology), is an Assistant Director of the CPFH. In this capacity, she assists the Director in policy planning for overall Center activities and is responsible for the development and implementation of the service program for women in Vanderbilt Clinic. She

also is involved in the Center's financial planning and the funding of its multi-faceted program. Prior to joining the CPFH, she served as Director of PRETERM, Washington, an innovative free-standing service facility, and lived for several years in North Africa.

REGINA LOEWENSTEIN, M.A. (Mathematics), is a Senior Research Associate in Public Health. As Director of the CPFH's Statistical Unit, she is consultant to many projects about statistical and computer techniques and supervises the computer services. In addition, she coordinates the collection of domestic demographic and vital statistics, helps to plan the clinic service statistics system and the more general clinic evaluation system and assists in planning nation-wide and local research efforts. She has extensive experience in the teaching of statistical and research techniques.

SUSAN GUSTAVUS PHILLIBER, Ph.D. (Sociology, Demography), is Associate Professor of Public Health and Assistant CPFH Director for adolescent social science research. Her current interests are causes and consequences of adolescent sexuality, contraceptive use, and pregnancy. Her publications include a textbook in population studies and articles on fertility socialization and population education. Prior to joining the CPFH, she was an Associate Professor of Sociology at the University of Cincinati.

JOANNE E. REVSON, M.P.H. (Health Administration and Planning), is a Senior Staff Associate. Her present interests include the planning, management and evaluation of international health programs, particularly in the Francophone countries of Latin America and Africa, where she is presently involved in several innovative family health service delivery projects. She served for two years as an Assistant Visiting Professor of Family Health at Ecole Nationale de la Sante Publique, France, helping implement a teaching program in population for the Francophone countries. She presently is a Dr.P.H. candidate at the School of Public Health.

ALLAN ROSENFIELD, M.D. (Obstetrics & Gynecology), is Director of the Center and Professor of Public Health and Obstetrics & Gynecology. Prior to moving to Columbia he taught obstetrics and gynecology at the Lagos University Medical School in Nigeria for a year and then spent six years in Thailand for the Population Council as medical advisor to the Ministry of Public Health and country representative. He also served as Associate Director of the Council's Technical Assistance Division, responsible for integrated maternal and child health and family planning programs.

JOHN A. ROSS, Ph.D. (Sociology, Demography), is an Associate Professor of Public Health. He has had extensive experience in demographic and applied research on fertility control programs in developing countries. He has contributed a number of key publications in the field and recently has been involved in detailed analysis of data from the Korean family planning program. He previously worked abroad in Turkey and Korea, served as Director of the Research and Evaluation Unit at the Population Council, and developed, for the Council, the International Committee for Applied Research in Population (ICARP).

PEARILA BRICKNER ROTHENBERG, Ph.D. (Sociomedical Sciences), is an Assistant Professor of Public Health. Her background is in Sociomedical Sciences and her major interests include studying adolescent sexual, contraceptive and pregnancy behaviors, as well as conducting research about family planning and perinatal services for adolescents. She also has served as evaluation director at the DOOR, an innovative free-standing multiservice center for adolescents in New York City.

KRISHNA ROY, M.A., Ph.D. (Economics, Demography), is an Assistant Professor of Public Health. She has worked for several years in demographic and economic compilation and analysis in India, Sudan, Peru and Guatemala and presently is focusing her attention on CPFH research efforts in Guatemala and Peru.

MICHELE GOLDZIEHER SHEDLIN, M.A. (Sociomedical Sciences), is a Program Coordinator, working primarily in Mexico, where she has an appointment in the Directorate of Maternal and Child Health and Family Planning of the Mexican Ministry of Health. She is involved in research on cultural aspects of contraceptive decision-making, the utilization of traditional practitioners in family planning programs, and the role of beliefs and body concepts in the acceptability of contraceptive methods and in the provision of family planning information and education. She is a Ph.D. candidate in Sociomedical Sciences.

KATHRYN SPEERT, M.S. (Library Sciences), is Head Librarian of the Library/Information Program and is the author of the first thesaurus published in the population field. Previously she worked as Columbia University's Psychology Librarian and then, on a part-time basis, was with the Parkinson Information Center at the Hea n Sciences Library where she was responsible for the pu.-lication of their bi-weekly literature alerting list, now produced by the National Library of Medicine, and for their thesaurus.

GIORGIO R. SOLIMANO, M.D., is an Associate Professor of Public Health Nutrition, working in both the CPFH and the Institute of Human Nutrition. He is a Pediatrician with extensive experience in the field of nutrition and was an Associate Professor of Pediatrics and Public Health at the University of Chile prior to coming to the United States. He is involved in the CPFH international and teaching programs, in the areas of international health and nutrition.

CAROL HOPKINS VALENTINE, M.P.H. (Population), is a Program Coordinator in the teaching program. Her extensive experience in international education, plus her work in Africa, led to her interest in population teaching and research projects.

WALTER WATSON, Ph.D. (Sociology, Demography), is a Senior Research Associate. He has had extensive experience in the area of family planning research and evaluation in Korea and at the Population Council, where he also coordinated the ICARP program and served as Editor of Studies in Family Planning.

JUDITH WILKINSON, M.S. (Library Sciences), is an Assistant Librarian. She has been with the Center library from its early stages and has contributed to the planning, development, and growth of the library program. Previously, she worked at Columbia University's Parkinson Information Center.

Administration
JAIRO RIOS, Business Manager
BARBARA GRAVES, Administrative Assistant
JOHN RAMIREZ, Accountant
ALICE CAPOZZI, Accountant/Secretary
PI-YU TING, Computer Programmer

Graduate Research Assistants, 1978-1979
CANDACE CLARK, M.A. (Sociology), is a Ph.D. candidate in Sociomedical Sciences.

ELLAN COLE, R.N., M.S.N. (Nursing), is a Ph.D. candidate in Sociomedical Sciences.

ELIZABETH KELLNER, M.P.H., is a Dr. P.H. candidate in Population and Family Health.

MARIANNE LORENZELLI, M.S.W. (Community Organization) is a Ph.D. candidate in Sociomedical Sciences.

VERA PLASKON, R.N., M.A. (Nursing), is a Dr. P.H. candidate in Population and Family Health.

Family Planning Counselors
ALICIA ALVAREZ
MARIA COLLADO
ARTURO DEL PINO
AURORA GREANEY
AUREA MARTINEZ

Support staff
DORIS DELIZ
MARGARET DE MARRAIS
MARY HAIRSTON
SALLY HAMMER
ADELAIDE HIRSCHHEIMER
WAYNE HORACE
TERESA LENG
ALINA MARTIN
DENISE MELLIGON
CONSTANCE ORTEGA
SYDNEY SPERO
IRENE STEGER
ANNETTE TOPILOW

Part time staff
NANCY FOLGER, Special Assignments
SHANTA MADHAVAN, Research Assistant
RUTH OETTINGER, Librarian

PUBLICATIONS

Manuals for Evaluation of Family Planning and Population Programs

Gorosh, M.E., and D. Wolfers. *The Standard Couple Year of Protection: a Methodology for Program Assessment*. New York: Columbia University, 1977.

Pasquarella, B.G., and S.M. Wishik, with the assistance of W. Williamson. *Evaluating Training Effectiveness and Trainee Achievement: Methodology for Measurement of Changes in Levels of Cognitive Competence*. New York: Columbia University, 1975.

Reynolds, J. A. *Checklist for Evaluative Overviews of Family Planning Program Activities*. New York: Columbia University, 1973. (Available in English and in Spanish)

Reynolds, J. A. *Framework for the Design of Family Planning Program Evaluation Systems*. New York: Columbia University, rev. ed. 1973. (Available in English and in Spanish)

Reynolds, J. A. *Framework for the Selection of Family Planning Program Evaluation Topics*. New York: Columbia University, rev. ed. 1973. (Available in English and in Spanish)

Reynolds, J., and R. Ramaprasad. *A Method for Estimating Future Caseload of Family Planning Programs*. New York: Columbia University, rev. ed. 1973. (Available in English and in Spanish)

Reynolds, J. *Operational Evaluation of Family Planning Programs Through Process Analysis*. New York: Columbia University, rev. ed. 1973. (Available in English and in Spanish)

Wishik, S., and D.W. Helting, with the assistance of I.T. Johnson, B. Pasquarella, and R. Ramaprasad. *The Fertility Pattern Method: Estimation of Fertility Change by Retrospective Quasi-Cohort Analysis of Cross-Sex Ratio of Fertility Patterns*. New York: Columbia University, 1972.

Wishik, S.M., and K.H. Chen. *Couple Year of Protection: A Measure of Family Planning Program Output*. New York: Columbia University, 1973.

Wishik, S.M., and P.P. Talwar. *Guidelines for Selective Supervision of Local Service Units in Family Planning Programs*. New York: Columbia University, 1976.

Other Monograph Publications

Moore-Cavat, E.C. *International Inventory of Information on Induced Abortion*. New York: Columbia University, 1974.

Speert, K.H., and S.M. Wishik. *Fertility Modification: Thesaurus With Focus on Evaluation of Family Planning Programs*. New York: Columbia University, 1973.

Wishik, S.M., and J.F. Hulka. *Casebook for the Intrauterine Contraceptive Device*. New York and Chapel Hill, N.C.: Columbia University, 2d ed. 1974. (Available in English, Spanish, and French)

Selected Reprints

Atkinson, L., R. Castadot, A. Cuadros, and A.G. Rosenfeld. "Oral contraceptives: considerations of safety in home ... distribution." *Studies in Family Planning* 5(8):242-249, August 1974.

Brown, L.A., and S.C. Phillips. "The diffusion of a population-related innovation: the Planned Parenthood affiliate." *Social Science Quarterly* 58(12):215-228, September 1977.

Chen, K.H., S.M. Wishik, and S.C. Scrimshaw. "Effects of unstable sexual union on fertility in Guayaquil, Ecuador." *Social Biology* 21(4):353-359, Winter 1974.

Daraby, K., and R.M. Richart. "Collaborative study of hysteroscopic sterilization procedures: preliminary report." *Obstetrics and Gynecology* 49(1):48-54, January 1977.

Daraby, K. "Community development study: lessons for family planning." *Journal of the Community Development Society* 7(2):59-69, Fall 1976.

Elkins, H. and O.S. Nordfeng. "Service statistics: aid to more effective fp program management." *Population Reports* Series J, No. 17 (321-334), November 1977.

1977-78 ANNUAL REPORT

180

Gorosh, M.E., and S.M. Wishik. "The role of Service Statistics in Evaluation: indicators for the evaluation of MCH/FP programs." Washington, D.C.: Pan American Health Organization. In press.

Gustavus, S.O., and C.A. Huether. "Population education in the United States: a survey of secondary schools." *Family Planning Perspectives* 7(5):203-207, September-October 1975.

Gustavus, S.O. and C.A. Huether. "Population education in the social studies classroom: a survey of secondary school teachers." *Social Education* 41(1):28-32, January 1977.

Gustavus, S.O. "The family size preferences of young people: a replication and follow-up study." *Studies in Family Planning* 4(12):335-342, December 1973.

Gustavus, S.O., and K.G. Mommsen. "Black-white differentials in family size preferences among youth." *Pacific Sociological Review* 16(1):107-119, January 1973.

Gustavus, S.O. "The Commission Report: implications for women." *Social Science Quarterly* 53(3):470-473, December 1972.

Hemachudha, C., and A.G. Rosenfield. "National Health Services and Family Planning, Thailand, a case study." *American Journal of Public Health* 65(8):864-871, August 1975.

Isaacs, S.L., and A. Sheffield. "Population policy and program action: the Latin American experience." *International and Comparative Public Policy* 1(2):83-112, Winter-Spring 1977.

Isaacs, S.L., and H. Sanhueza. "Induced abortion in Latin America: the legal perspective." In *Epidemiology of Abortion and Practices of Fertility Regulation in Latin America*. Washington, D.C.: Pan American Health Organization, 1975, pp. 39-49. (PAHO Scientific Publication No. 306)

Isaacs, S.L. "Nonphysician distribution of contraception in Latin America and the Caribbean." *Family Planning Perspectives* 7(4):158-164, July-August 1975.

Jones, J.E. *Administrator's Manual*. Washington, D.C.: Preterm Institute, 1976.

Loewenstein, R., G. Widmer, and S-P May Lan. *Health Profile of Upper Manhattan*. New York: Columbia University, Center for Community Health Systems, 1975.

Loewenstein, R. "Two approaches to health interview surveys." *Proceedings of the Social Statistics Section, American Statistical Association*: 332-336, 1971.

Measham, A.R. "Population policy 1977: a reexamination of the issues." *Preventive Medicine* 6(1):92-103, 1977.

Measham, A.R., and A. Villegas. "Comparison of continuation rates of intrauterine devices." *Obstetrics and Gynecology* 48(3):336-340, September 1976.

Measham, A.R. "Self-prescription of oral contraceptives in Bogota, Colombia." *Contraception* 13(3):333-340, March 1976.

Nag, M. "Sterilization in India, 1965-75: an overview of research results." *Journal of Family Welfare* 23(2):3-19, December 1976.

Nag, M. "Population anthropologists at work." *Current Anthropology* 16(2):264-266, June 1975.

Presser, H.B. "Guessing and misinformation about pregnancy risk among urban mothers." *Family Planning Perspectives* 9(3):111-115, May-June 1977.

Presser, H.B. "Age differences between spouses: trends, patterns, and social implications." *American Behavioral Scientist* 19(2):190-205,1975.

Presser, H.B. "Early motherhood: ignorance or bliss?" *Family Planning Perspectives* 6(1):8-14, Winter 1974.

Richart, R.M., K. Darabi, and R.S. Nenwirth. "Female sterilization: an overview." In R.S. Nenwirth (ed) *Hysteroscopy*. Philadelphia: W.B. Saunders, 1975, pp. 81-101. (Major Problems in Obstetrics and Gynecology, Vol. 8)

Rosenfield, A.G. "Family planning programs: status report 1976." *Advances in Planned Parenthood*. In press.

Rosenfield, A.G. "Modern medicine and the delivery of health services: lessons from the developing world." *Man and Medicine*. In press.

Rosenfield, A.G. "The ethics of supervising family planning in developing nations: fewer physicians but more care." *The Hastings Center Report* 7(1):25-29, 1977.

Rosenfield, A.G. "Nursing and auxiliary personnel: a training guide for family planning programs." *Advances in Planned Parenthood* 11(4):185-190, 1976.

Rosenfield, A.G. "Injectable long-acting progestogen contraception: a neglected modality." *American Journal of Obstetrics and Gynecology* 120(4):537-548, October 1974.

Rosenfield, A.G. "Family planning programs: can more be done?" *Studies in Family Planning* 5(4):115-122, April 1974.

Rosenfield, A.G., and R.G. Castadot. "Early postpartum and immediate postabortion intrauterine contraceptive device insertion." *American Journal of Obstetrics and Gynecology* 118(8):1104-1114, April 1974.

Rosenfield, A.G., and C. Limcharoen. "Auxiliary midwife prescription of oral contraceptives." *American Journal of Obstetrics and Gynecology* 114(7):942-949, December 1972.

32-704 O - 78 - 13

Ross, J.A., and J.E. Forrest. "The demographic effect of family planning programs." *Population Index*. In press.

Ross, J.A., and K.S. Koh. "Transition to the small family: a comparison of 1964-1973 time trends in Korea and Thailand." In Y. Chang and P. Donaldson (eds) *Population Change in Asia and the Pacific*. Vancouver: Pacific Science Association, 1977. pp. 121-139.

Ross, J.A. "Acceptor targets." In C. Chandrasekaran and A.I. Hermalin (eds) *Measuring the Effect of Family Planning Programs on Fertility*. Dolhain, Belgium: Ordina Editions for the International Union for the Scientific Study of Population, 1975. pp. 55-91.

Roy, K. "Population policy from the southern perspective." In G.F. Erb and V. Kallab (eds) *Beyond Dependency: the Developing World Speaks Out*. Washington, D.C.: Overseas Development Council, 1975. pp. 95-110.

Scrimshaw, S.C. "Women's modesty: one barrier to the use of family planning clinics in Ecuador." In John F. Marshall and Steven Polgar (eds) *Culture, Natality and Family Planning*. Chapel Hill, N.C.: Carolina Population Center, 1976. pp. 167-183. (Carolina Population Center Monograph 21)

Scrimshaw, S.C. "Families in the city: changing values, fertility and socioeconomic status among urban in-migrants." In Moni Nag (ed) *Population and Social Organization*. The Hague: Mouton, 1975. pp. 109-130.

Scrimshaw, S.C. "Lo de nosotras: pudor and family planning clinics in a Latin American city." New York: Columbia University, 1973. (Available in English and in Spanish)

Sear, A.M. "Predictors of contraceptive practice for low-income women in Cali, Colombia." *Journal of Biosocial Science* 7(2):171-188, April 1975.

Stragefdin, I. and J.A. Ross. "Empirical demographic generalizations in response to family planning programs. In *International Population Conference, Mexico, 1977*. Liege, Belgium: International Union for the Scientific Study of Population, 1977. pp. 209-228.

Wishik, S.M., and S. Van der Vynckt. "The use of nutritional 'positive deviants' to identify approaches for modification of dietary practices." *American Journal of Public Health* 66(1):38-42, January 1976.

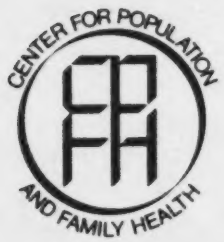
Wishik, S.M. "Nutrition, mother's health, and fertility: the effects of child-bearing on health and nutrition." *PAC Bulletin* 5(3):11-16, September 1975.

Wolters, D., and S.C. Scrimshaw. "Child survival and intervals between pregnancies in Guayaquil, Ecuador." *Population Studies* 29(3):479-496, 1975.

LIBRARY/INFORMATION

The Library/Information program houses a unique and extensive collection of published and unpublished materials on family planning program evaluation and development, with emphasis on programs operating in developing countries. The collection is available for use by Center staff, students, and visitors. The Library contributes bibliographic citations to a multi-university cooperative computerized information retrieval system, POPINFORM, developed with the assistance of the U.S. Agency for International Development. Both manual and computerized literature searches are performed on request for library clientele. Searches are provided free of charge to individuals employed by international organizations or situated in developing countries. Other staff activities include production of a thesaurus of family planning terms, The Fertility Modification Thesaurus, used for both manual and computerized retrieval of library documents, and involvement in the activities of the Association for Population/Family Planning Libraries and Information Centers-International, an organization which functions to facilitate cooperation among population libraries in the U.S. and abroad.

FINE DESIGN, NY



For further information write or call:

Allan Rosenfield, M.D., Director
Center for Population and Family Health
College of Physicians and Surgeons
Columbia University
60 Haven Avenue
New York City, N.Y. 10032
Telephone (212) 694-6960

Cable: POPHEALTH, New York

Columbia University is an equal opportunity employer

STATEMENT OF THE UNITED STATES CATHOLIC CONFERENCE

ON THE ADOLESCENT HEALTH, SERVICES AND

PREGNANCY PREVENTION AND CARE ACT OF 1978.

Considerable public attention has been focused on the matter of teenage pregnancy, and the Carter Administration and members of Congress have expressed concern and determination to utilize public resources to try to deal with the problem. We share the concern about teenage pregnancy, and we agree with the basic purposes of the bill, that is, to provide assistance to pregnant adolescents and to reduce the overall number of out-of-wedlock teenage pregnancies.

Notwithstanding our agreement with the basic purposes, we find that the legislation as proposed can and should be improved.

To begin with, the reasons for the bill as expressed in Sec. 2 (a) are somewhat misleading and should be more carefully written. The statement that "adolescents are at a high risk of unwanted pregnancy" is general and over-broad, and seems to create a crisis atmosphere in regard to teenage pregnancy. While it may be true that pre-marital sexual activity among teenagers has increased during the past twenty years, it is also true that overall rates of teenage childbearing have actually declined from 97.3 (per 1,000 women aged 15-19) in 1957 to 56.3 in 1975. The actual number of births to teenagers has remained about the same because of the relatively larger proportion of teenagers in the population. (Cf. the attached letter from Science, 31 March 1978, pertaining to this matter.)

The bill also makes reference to health and social problems associated with teenage pregnancy. For the sake of accuracy it is fair to note that many of the health problems are the result of poor nutrition and dietary habits, smoking, the use of alcohol and drugs, and generally poor self-image and maturity.

As Professor Frank Furstenberg notes in his study, "The widespread conviction that early childbearing precipitates a number of social and economic problems is founded on surprisingly little evidence." (Furstenberg, Frank, Unplanned Parenthood: The Social Consequences of Teenage Childbearing, (1976) New York, The Free Press.)

Attached is a reprint of the article "Abortion and Teenage Pregnancy", from the 1977 Respect Life Handbook which provides a careful analysis of teenage pregnancy. There seems to be some agreement among the specialists that the problem of teenage pregnancy is complex and that the factors influencing out-of-wedlock pregnancy are complex, but there is little agreement as to the solutions to the various problems.

The bill repeatedly speaks in terms of preventing teenage pregnancy. Unfortunately, the legislation leans toward programs of contraception, sterilization and abortion as the means of preventing births, but gives far too little recognition to the need for education, counseling and assistance to parents in motivating their adolescents to exercise self-restraint in regard to sexual activity and behavior. The proposed legislation is admittedly vague in regard to how teenage pregnancy is to be prevented, and how agencies providing services to teenagers will respect parental rights. Once again, there is a growing awareness that simply providing contraceptive services will not effectively solve the problem. As Kingsley Davis noted in a report to the Commission on Population Growth and the American Future, "The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable."

The proposed bill should be more explicit in assuring safeguards for informed consent on the part of teenagers who utilize services provided by governmental agencies and non-governmental agencies supported in whole or in part by government funds. This would extend to agencies that are part of any network or linkage as described in the bill. Informed consent has increasingly been looked upon as a way to safeguard freedom, and is especially important when dealing with matters of human sexuality. In addition, the bill should require participating agencies to establish mechanisms that will protect parents rights, notably the right to be informed regarding contraception, sterilization and abortion.

There is special need for informed consent provisions to protect teenagers and their families not only from direct coercion, but also from any subtle coercion regarding so-called "ideal family size", the dynamics of population growth, unsubstantiated predictions regarding the effects of childbearing on the future life of the adolescent.

To accomplish the purposes of the act, Title I establishes a "Grant Program" which authorizes grants to non-profit agencies. We believe that many agencies of the Catholic Church are already engaged in programs that would qualify them for grants. We urge Congress to emphasize that such agencies are not to be excluded because of the Church's moral teachings on abortion, sterilization and birth control. We also urge the Congress to caution other agencies against encouraging or promoting bias or prejudice against the Church and its agencies. We raise this point because there have been recent indications that some agencies involved in government-funded family planning programs have engaged in such anti-Catholic activities.

We also urge that agencies providing a specific service, such as a home for unwed mothers, not be forced to provide other services, such as abortion, sterilization and contraception, that are in conflict with the agency's moral principles. Valuable as the "linkage" concept may be to pull together already existing services, it should not impede the expansion of successful programs nor become an obstacle for an agency that has already demonstrated its competence in meeting the needs of pregnant women and their unborn children or new mothers and infants.

The bill as presently written seems to place heavy emphasis on the prevention of teenage pregnancy, but "prevention" is nowhere carefully defined. Abortion and sterilization should be absolutely excluded from any governmental program. Abortion involves the destruction of life of an unborn child, who is clearly an innocent party. In regard to sterilization, the potential for abuse has already been demonstrated both here and abroad. Moreover, contraceptives should not be provided to teenagers as a matter of government policy. This is a matter for the family and parents to deal with, and the government should not establish policies that preempt the prerogatives or responsibilities of the family unit. Greater emphasis should be placed on the programs and services that will assist pregnant teenagers to carry their unborn children to term, and to fulfill the responsibilities of parenthood.

At the same time, the bill should address the prevention of first or repeat pregnancies among unwed teenagers in terms of programs that assist and support families and programs that inform and motivate teenagers to avoid pre-marital sexual activity. Other Committees of the Congress have held hearings on the question of adolescent pregnancy and sex education, and the concept of education seemed to be unduly narrowed to providing information on and access to contraception. We believe that education is a much broader concept, and that efforts must be taken to assist families in the fulfillment of their educational role and provide resources that will enable parents and adolescents to work out the problems of sexual development together in a harmonious manner.

Conclusion

The United States Catholic Conference wishes to be on record in support of government assisted efforts to provide assistance and care to pregnant teenagers so that they may carry their children to term. We agree with the basic intent of the Congress to meet this need and to help diminish the incidence of out-of-wedlock teenage pregnancies. The teenage pregnancy bill may be a useful means of accomplishing these goals, and we urge a further revision of the proposed bill to protect the rights of individuals and families and to direct the energies of government and private agencies in appropriately assisting families, parents and pregnant adolescents.

Teenage Pregnancies

In discussing the proposed increase in the budget of the National Institute of Child Health and Human Development, Barbara J. Culliton (News and Comment, 3 Feb., p. 508) uses the term "epidemic" to refer to teenage pregnancies. This is a scientific term and should be used with caution. The rate of teenage pregnancy may well be increasing, but we do not have a reliable direct measure of conception rates, and not all increases over time deserve the term "epidemic." It would seem safer to focus on age-specific birthrates. They have been falling since 1969 for 18- to 19-year-olds; they were approximately steady from 1970 to 1973 and have been falling since then for the 15- to 17-year-olds; and they have been approximately steady since 1970 for the 10- to 14-year-old group (*1*). The total number of births to teenagers has been falling since 1970. In the face of these data, the term "epidemic" seems unwarranted. What has been increasing rapidly are society's awareness of and concern about teenage pregnancies.

Culliton also notes that more than half of the estimated 1 million teenagers who became pregnant last year chose to keep their babies. This information is misleading. The Alan Guttmacher Institute (which made the estimate) suggests that more than 400,000 of those pregnancies ended in miscarriages and abortions and less than 600,000 in births (*2*, p. 10). The figure for 1975 (the latest year for which published data are available) was 594,880 live births to females under 20. But more than half, 354,968, were to 18- and 19-year-olds. Moreover almost 250,000 of these, or 70 percent, were married (*1*; *2*, p. 11). Thus approximately 42 percent of the live births to women under 20 were to married 18- and 19-year-olds.

Many may believe, and we may agree, that childbearing should be delayed until the mother is in her 20's, but there is nothing immoral, illegal, or contrary to this society's values about 18- and 19-year-old married women keeping their babies. Teenage pregnancy is a national problem, but its dimensions should be examined more carefully.

LORRAINE V. KLERMAN
Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Massachusetts 02154

JAMES F. JEKEL
Yale School of Medicine, New Haven, Connecticut 06510

References

1. *Mon. Vit. Stat. Rep.* **26** (No. 5, Suppl.), 9 (1977).
2. *11 Million Teenagers* (Alan Guttmacher Institute, New York, 1976).

Abortion and Teenage Pregnancy

In 1973 the U.S. Supreme Court issued an unprecedented ruling. Abortion, it said, is virtually a private matter for the woman to decide. "This right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy" (*Roe v. Wade*, slip opinion, pp. 37-38). Beginning in the fourth month of pregnancy, the Court held, the state could impose some health restrictions on the performance of abortion, if it chose to do so, and in the sixth or perhaps seventh month it could—if it so chose—extend some protection to the "potential human life" in the mother's womb (full rights of human personhood are not to be recognized by the law until at least birth). But, whether in the third, sixth, or ninth month of pregnancy, the private right of the woman to obtain an abortion is always paramount.

The Court's tragic decision is based on two fundamental errors.

First, the life of the unborn child is assigned a moral value of zero.

Second, abortion is essentially considered in a vacuum, apart from all other human relationships. The woman, in consultation with her physician, has the final power to decide whether and why the abortion should be performed. No one else has any say in the matter.

Yet—despite what the Court said—it is a fact that the generation of new human life is an event of immense social importance. Court decisions do not create this reality, nor can they destroy it. Many aspects of this process of generation are personal, but none can properly be called altogether private—that is, pertaining to the individual alone. When the Court called abortion a private matter for the woman to decide, it adopted a legal fiction—a fiction which helps society silently condone the performance of what it knows to be a morally shameful act.

At least since 1969, when national records on the subject were first kept, about one-third of all legal abortions each year have been performed on teenagers—upwards of 300,000 in 1974. Teenagers make up a significant single group of abortion recipients. They are also the most humanly vulnerable group. In what follows we shall discuss in some detail the situation of the pregnant, unwed teenager. We shall conclude with several reflections on why changes are needed in public policy.

TEENAGE ABORTION

The incidence of legal abortion has been increasing dramatically since it was first introduced in an appreciable way in several states in 1967. It is estimated that in 1975 the number of abortions in the United States exceeded one million. Apparently, the annual figure has not yet peaked (a phenomenon which usually occurs several years after a permissive abortion policy has been introduced). Teenagers, along with other age groups, have increasingly turned to abortion, and this trend will probably continue for several years.

The available data do not make it clear how many of the teenagers who obtain abortions are married and how many are not. However, it seems safe to assume that the vast majority are unmarried. The estimated national figure for unmarried women obtaining abortions in all age groups was 70.9 percent in 1974. Most likely, the figure for the teen years was even higher.

In light of this, one can hardly ignore the question of the relationship between the pregnant, unmarried daughter and her parents. This question becomes even more important when we realize that an estimated 13,000 girls under the age of 15 obtained abortions in 1974. (According to the Center for Disease Control this age group had more abortions than live births.)

CHILDBEARING AMONG TEENAGERS

Despite the contrary impression, overall rates of teenage childbearing have actually fallen in recent years—from a high in 1957 of 97.3 births per 1,000 women (ages 15 to 19) to a low in 1975 of 56.3. This substantial decline, however, has not been as extreme as that experienced by older women. For the 20-to-24-year-old age group, for example, the rate dropped from 258.1 in 1960 to 114.7 in 1975. As a result, births to teenagers now figure more prominently among all births—nearly one-fifth of all births in 1975.

While teenage birth *rates* have gone down in recent years, the *number* of women aged 10 to 19 years has grown—from around 15 million in 1960 to over 20 million in 1975. As a result, the annual *total number of births* to teenagers has not declined (as might have been expected from the falling teenage birth rate) but has stayed about the same (509,000 in 1960 and 594,900 in 1975).

In 1975 nearly 40 percent of all teenage childbearing was out of wedlock (233,500 births out of 594,900). In addition, it is estimated that a significant percentage of teenage marital births are conceived prematurally.

OUT-OF-WEDLOCK BIRTHS—IN GENERAL

Social scientists measure out-of-wedlock births in various ways—by total numbers, by illegitimacy ratios (the num-

NC PHOTO BY SUSAN MCKINNEY

200

ber of out-of-wedlock births compared to the number of live births), and by illegitimacy rates (the number of out-of-wedlock births per 1,000 unmarried women of childbearing age).

For purposes of measuring general historical trends, special attention will be given here to illegitimacy rates.

From 1920 to 1940 the illegitimacy rate remained relatively stable:

Year	Total No.	Rate
1920	86,400	8.7
1930	90,800	7.8
1940	103,000	8.0

However, from 1940 to 1970 the illegitimacy rate rose steadily. By 1970 the rate had increased more than threefold:

Year	Total No.	Rate
1940	103,000	8.0
1945	128,200	10.5
1950	148,400	14.5
1955	189,700	19.5
1960	230,400	21.7
1965	297,100	23.4
1970	398,700	26.4

Since 1970 the rate has remained high, declining slightly for the most part, but with a small upturn in 1975:

Year	Total No.	Rate
1970	398,700	26.4
1971	401,400	25.6
1972	403,200	24.9
1973	407,300	24.5
1974	418,100	24.1
1975	447,900	24.8
1976	NA	NA

OUT-OF-WEDLOCK BIRTHS—TEENAGERS

From 1940 to 1965 every age group of childbearing women showed an increase in the rate of illegitimacy. Those aged 15 to 19 showed the lowest rate of increase. However, from 1965 to 1975 every age group experienced a decrease in the rate—except the 15-to-19-year-old group, among whom the rate continued to increase.

The birth rate—both legitimate and illegitimate—has been declining for women 20 years and older. But, as noted above, the overall birth rate for teenagers has not been declining as fast as that for those 20 years and older. Here, the illegitimate birth rate for teenagers continues to increase. As a result, out-of-wedlock births have become more concentrated in the teen years—52 percent of the total in 1975 (40 percent in 1955, 44 percent in 1965).

Illegitimacy Rates by Age Groups 1940, 1965, 1970, 1975

	15-19	20-24	25-29	30-34	35-39	40-44
1940	8.7	10.6	8.1	5.8	3.4	1.2
1965	17.5	39.3	48.4	37.2	17.4	4.5
1970	22.4	38.4	37.0	27.1	13.6	3.5
1975	24.2	31.6	28.0	18.1	9.1	2.8
% Change 1965-75	+38%	−20%	−42%	−51%	−48%	−42%

WHY?

Authorities disagree about what factors affect out-of-wedlock births and what should be done in response to the problem.

Improvements in health care can result in increased fertility—and thus more births, including out-of-wedlock births. The age at menarche (when menstruation first occurs) has been decreasing in the Western world for many years at the rate of four months per decade (the average age is now 12—though wide variations occur). Presumably this has been occurring as a result of improved health conditions. The young adolescent may not be fully fertile, however, for another two and one-half or three years following the onset of menarche. In light of these two facts, one authority estimates that between 1940 and 1960 fertility was increasing among women 15, 16, and perhaps 17 (Cutright). Improved health care presumably has also led to a reduction in spontaneous abortion and to reductions in involuntary sterility (primarily for women beyond their teen years).

However, these health factors certainly do not fully explain the rise in illegitimacy rates since 1940. And in no way do they explain the declines since 1965 among women aged 20 or older.

One study concluded that, beyond improved health conditions, the main factor in the rise in the illegitimacy rates between 1940 and 1960 was an increase in sexual activity (Cutright).

This is the conclusion of one study, and it is not the last word. More important, changes in sexual behavior are themselves related to other social changes and conditions, especially changes in family structure and social policy toward the family.

One authority considers the rise in premarital pregnancies and the rise in the rate of teenage marriages following World War II to be closely tied to economic and social changes of that time (Weeks).

Let us look at teenage childbearing behavior in particular in the 1960s and 1970s.

The incidence of teenage out-of-wedlock childbearing will be directly affected by the incidence of teenage marriage. Some argue that at the beginning and end of the period 1960 to 1974 the percentage of teenage *births* conceived out-of-wedlock remained about the same, but, because of a downturn in teenage marriages, the proportion of these births that were actually *born out-of-wedlock* increased substantially (Campbell).

This analysis does not claim that the level of teenage non-marital sexual activity or the incidence of teenage out-of-wedlock conceptions had not increased. As stated above, since the late 1960s teenagers have increasingly turned to abortion as a solution to the out-of-wedlock pregnancy. Other studies indicate that nonmarital teenage sexual activity has been increasing in recent years (Zelnik and Kantner). With respect to the increase in teenage sexual activity, Weeks states that "the breakdown in social control during the 60s and early 70s is quite striking" (Weeks, p. 58).

Some studies correlate the availability of legal abortion with recent declines in the rate of illegitimacy (Sklar and Berman). Increased use of contraception may also account for some of the decrease.

Not surprisingly, some advocate contraception and abortion as the means to combat teenage illegitimacy.

However, the use of contraception by the unmarried teenager is notoriously ineffective. Unmarried, emotionally immature teenagers are not the same as married, emotionally mature adults. As it is, the failure rate in contraceptive use among married adults is fairly high (Cutright, pp. 417-418). In contrast to the married, the sexual behavior of the unmarried teenager is irregular, infrequent, and generally unplanned. Further, the behavior is often highly romanticized and the values of "spontaneity" and "naturalness" may be highly prized. Recent studies also show that sexually active teenagers possess a poor knowledge of the biology of reproduction (Zelnik and Kantner).

For reasons such as these, those who advocate contraception as a solution for the problem of out-of-wedlock teenage pregnancies consider abortion as an essential "backstop" method. An abortion will surely prevent a birth.

From 1965 to 1975 abortion and contraception were increasingly available in American society—but during this period the teenage illegitimacy rate continued to increase (though at a slower pace). One should anticipate that in the future abortion will be of even greater importance as an essential "backstop" for the "pragmatic" problem solvers.

Predictably, those promoting teenage contraception and abortion are looking for ways to make contraception and abortion more "accessible" to the unmarried teenager. Emphasis has shifted from community clinics to the schools.

In recent years, legal and social barriers inhibiting teenage access to contraception and abortion have become less and less. However, the natural barriers to effective use may very well remain.

Even if efforts to make contraception and abortion more "accessible" should succeed in "solving" the problem of out-of-wedlock teenage births, would we be a better society for it? What problems would have been left unattended? What new problems would have been created?

[illegible]
A MORE REFLECTIVE LOOK

One sociologist scores the advocacy of contraception for teenagers as typical of the American character—a misplaced trust in technology to solve human problems.

> The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place: it reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable (Davis, p. 253).

The same could be said about abortion as a problem solving tool for teenage out-of-wedlock births.

It is often assumed that little or nothing can be done to affect the sexual behavior of teenagers. At the same time, studies are produced which show that teenage sexual behavior has been affected—over the last several years it has increased. Today, U.S. teenage childbearing rates are among the highest in the world—higher even than those in many less developed nations. Are we to assume that teenagers in third world countries are more effective contraceptors and have greater access to abortion? Or that only health conditions explain the differences?

The sexual behavior of teenagers not only can change over time but can vary among individuals and groups. For example, teenage girls who are more highly motivated to achieve future goals are more likely to delay the initiation of sexual activity—and thus the possibility of an out-of-wedlock pregnancy (Furstenberg, 39-42).

American culture currently romanticizes sexual activity. It was not always so. However, teenagers—growing up, experiencing life for the first time, looking to authority figures outside the family—are most susceptible to the new cultural "norms."

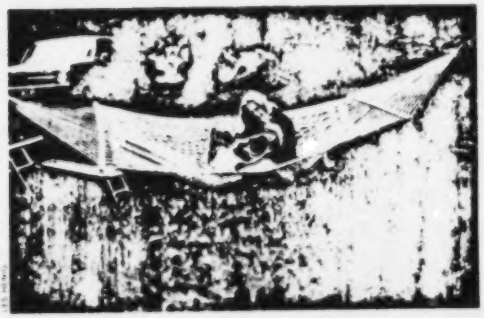
The problem is only compounded by the fact that other societal patterns—even laws—separate parent and child. In some instances society seems to expect each individual teenager to discover the meaning of human life all alone. In such a system of moral development many serious and permanent mistakes will be made. The gifted few may succeed. Would we leave teenagers to their own devices with respect to intellectual development? Society—both from within the home and from outside the home—has always exercised guidance and discipline in the moral and social development of its teenage members. This guidance and discipline is no less important today than in the past.

Breakdown in social controls over sexual activity are not always entirely obvious. Studies show that nonmarital teenage sexual activity is often initiated at the insistence of the male. One way of controlling the nonmarital sexual activity of the male in the past was through paternity laws—but these now are often meaningless in practice. (In this sense, is abortion on request the logical out-

NC PHOTO

come of a lessening of the male's responsibility for his sexual actions?) At the same time the social structures that used to ensure an orderly process in the selection of a marriage partner are no longer or not always there. As a result, the woman's search for a marriage partner—in the marriage oriented society that we still are—is more apt to begin earlier and end either in an out-of-wedlock pregnancy or a teenage marriage.

Social factors—at first glance apparently unrelated—may affect the incidence of teenage out-of-wedlock births. Studies show that the majority of nonwhite as well as white teenage girls hold nonmarital sexual activity to be morally wrong. However, whites more than nonwhites are more likely to legitimate an out-of-wedlock pregnancy by marriage. Some postulate that marriage might only aggravate the economically disadvantaged positions of the nonwhite: it might be several years before the teenage father would have a job that could support a family adequately. At the same time, the teenage mother would be separating herself from the immediate support of her existing family unit (Furstenberg, pp. 68, 71-75).



OUT-OF-WEDLOCK BIRTHS—THE EXTENT OF THE PROBLEM

Those who advocate contraception and abortion as the solution to teenage out-of-wedlock births may not necessarily perceive the basic problem in the same way.

Some emphasize the reduction of all teenage childbearing—marital and nonmarital—and, in this sense, the concern should perhaps more properly be classified as population control.

Others stress the special social and medical problems associated with teenage out-of-wedlock childbearing.

A recent study concluded: "The widespread conviction that early childbearing precipitates a number of social and economic problems is founded on surprisingly little evidence." (Furstenberg, p. 12). It is not that such problems do not exist (the study confirmed the general impression that they do), but that their precise nature is not well understood and, as a result, inadequate solutions are proposed.

This same study found that over a five-year-period some teenage unwed mothers succeeded where others, in the same general circumstances, did not. "One of the most impressive findings was the diversity of responses to a common event. . . . The outcome at the five-year follow-up was enormously varied; in fact, by the time of the last interview, the sample hardly could have been more diverse in every important area we explored." (Furstenberg, pp. 218-219).

The most important question is whether any medical or social problems are so great as to justify the taking of unborn human life. The Church's teaching on respect for human life shows the principle that underlies this kind of problem solving to be incompatible with human dignity. Innocent human life can never be taken just because to do so is pragmatic—that is, it is possible, it is easier than its alternative, it "works," so it should be done. The humane way may very well be the more challenging way.

We must ask not only what are the human costs of bearing a child out-of-wedlock, but what are the human costs of aborting this yet unborn child. Is the loss of human life nothing? Does the woman who consents to the destruction of the new life within her remain indifferent to the act—or is a sense of freedom that a "problem" has been gotten rid of a morally praiseworthy quality? What is the effect on society itself when it adopts highly utilitarian social policies which violate fundamental human rights?

In the case of adolescent girls, there is already some realization that they become resentful of parents who force "the abortion solution" on them. Moreover, abortion counselors tell young people to expect some alteration in the boy/girl relationship after the abortion. The young woman, especially, has a changed attitude toward the boy, and apparently many of these relationships disintegrate rapidly.

As a medical procedure abortion presents threats to the life and health of any woman. But the adolescent girl is at risk in several respects. The teenager is more apt to delay seeking an abortion. But late-term abortions are medically the most dangerous kind. Yet a full-scale educational effort to convince teenagers that sex is a simple, uncomplicated fact of life and that, if they become pregnant, abortion is available on request, is generating pressure which leads teenagers to abort, glossing over the important fact of inherent danger.

It is commonly assumed that a young unmarried girl can abort an existing pregnancy and have children later when she wants them. But things may not be that simple. For example, studies—in various parts of the world—are showing that young women whose first pregnancies are aborted are much more likely than average to have subsequent pregnancies which result in premature births. Prematurity, in turn, has long been known to be associated with an increased incidence in cerebral palsy, mental retardation, and lesser forms of damage to the central nervous system.

such as learning disabilities (Hellegers). As abortion becomes the solution to premarital pregnancies, married couples and society may later have to pay the human and financial costs of a growing number of mentally and physically damaged children.

There is every reason to expect that young women who are rushed into abortion by social and cultural pressure will distrust and resent a society that misled them about the nature and long-range effect of the action they were encouraged to undertake.

Teenage pregnancy is not simply a result of ignorance or failed contraception. In many cases, the teenager's sexual irresponsibility is a symptom of personal insecurity—of a need for love, affection, and self-affirmation. Pregnancy is not necessarily unintended or unforeseen. And, while pregnancy may complicate existing personality difficulties, in such cases, so also the destruction of the unborn child may simply reinforce the teenager's low estimate of herself or diminish her perceived ability to cope with and overcome problems. Destroying the fetus in such cases may well be a weapon for destroying the mother, too.

SOCIAL AND PUBLIC POLICY

Today, sexuality is often regarded as a plaything. In such an atmosphere it is not surprising that sexual relationships between men and women tend to become exploitative while the broader social ramifications of human sexuality are lost sight of or are even positively rejected. The newly conceived human life is, then described as an intruder. When human sexuality is not accorded its proper dignity, it is consistent—though sad—that the unborn child, the fruit of the human sexual relationship, is regarded as nonhuman.

Examination of the facts about teenage childbearing, especially teenage out-of-wedlock births, makes it clear that "adult" standards of moral conduct are being extended to the not-yet-mature adolescent. But in this area, as in others, contemporary society suffers from moral impoverishment. Thus, the not-yet-mature adolescent will not find life guidance in the not-yet-mature standards of society at large.

The notions of social control and social discipline refer to more than parents' responsibility for their children. General social policy toward the family will condition the expression of family relationships.

Americans have traditionally considered freedom as both a social and personal value. Increasingly, however, freedom is being seen simply in terms of the individual. American public policy seems to have adopted this more narrow viewpoint.

But absolute or virtually absolute personal freedom is quickly emptied of meaning. The other goods of the human person, as well as the manifest goods that flow from human relationships, will time and again be compromised in the name of a nebulous, all-pervasive individual freedom.

The individual is never perfectly autonomous. Whether or not it is acknowledged, there always exists a tension between personal freedom and the good of society. Nowhere is this more evident than in the family, where the individual establishes self-identity and exercises his or her freedom while respecting the rights of other family members and the good of the family unit.

The threats to the family posed by an excessive concentration on individual freedom were graphically expressed by the U.S. Supreme Court in its 1973 abortion decisions.

These decisions represent the culmination of Court decisions over a period of several years which were unfavorable to the family (Noonan). Furthermore, on July 1, 1976, the Court issued another round of abortion decisions—with specific reference to the family. It ruled that the women's right to abort the child within her can be exercised without her husband's consent, or, if she is a minor, without her parent's consent (*Planned Parenthood of Central Missouri v. Danforth*).

Several public policy recommendations require attention.

- The fundamental errors of the 1973 abortion decisions must be corrected. The most viable way to do this is through an amendment to the U.S. Constitution guaranteeing the basic right to life of the living but unborn child.
- The United States needs to develop a family policy that is positive toward and supportive of family life. Such a policy must extend beyond a narrow concern for the techniques of family planning and must be based on a broader vision which respects and encourages the basic goods of human life.
- Government policy and programs should be directed at removing those conditions which tempt or in some sense force a woman to turn to abortion to solve problems. Societal attitudes toward out-of-wedlock pregnancies have changed. The recriminations that society traditionally levied at both unwed mother and child have been more and more put aside—and rightly so. No girl pregnant out-of-wedlock should be abandoned to her own resources—and perhaps to an abortion. And no child should have to suffer any legal or social restrictions because he or she has been designated illegitimate.

IF WE WANT TO LOVE SOME BUTTERFLIES
WE FIRST MUST CARE FOR A FEW CATERPILLARS
CARDINAL GLENNON MEMORIAL HOSPITAL FOR CHILDREN

REFERENCES

Campbell, Arthur A. Deputy Director, Center for Population Research, National Institute of Child Health and Human Development, HEW. Personal communication.

Center for Disease Control: Abortion Surveillance Reports, various years (1975 in press). Center for Disease Control, HEW, Atlanta, GA.

Clague, Alice J. and Stephanie J. Ventura. *Trends in Illegitimacy, United States, 1940-1965*. National Center for Health Statistics, HEW, Series 21, No. 15. Washington, D.C., 1968.

Cutright, Phillips. "Illegitimacy in the United States: 1920-1968," in *Commission on Population Growth and the American Future, Research Reports*, Vol. 1 (eds. Charles F. Westoff and Robert Parke, Jr., Washington, D.C.: GPO, 1972), 375-439.

Davis, Kingsley. "The American Family in Relation to Demographic Change," in *Commission on Population Growth and the American Future, Research Reports*, Vol. 1 (eds. Charles F. Westoff and Robert Parke, Jr., Washington, D.C.: GPO, 1972), 235-265.

Furstenberg, Frank F., Jr. *Unplanned Parenthood: The Social Consequences of Teenage Childbearing*. NY: The Free Press, 1976.

Grabill, Wilson H. *Premarital Fertility*. Current Population Reports, Special Studies, Series P-23, No. 63. Aug. 1976. U.S. Bureau of the Census.

Hellegers, Andre E., M.D. "Medical and Ethical Problems in Adolescence." Washburn Memorial Lecture in Pediatrics, University of Colorado School of Medicine, Denver, May 5, 1975.

National Center for Health Statistics, HEW. "Summary Report, Final Natality Statistics, 1973," *Monthly Vital Statistics Report*, Vol. 23, No. 11 (Jan. 30, 1975); "Advance Report, Final Natality Statistics, 1974," *Monthly Vital Statistics Report*, Vol. 24, No. 11 (Feb. 13, 1976); "Advance Report, Final Natality Statistics, 1975," Vol. 25, No. 10 (Dec. 30, 1976).

Noonan, John T., Jr. "The Family and the Supreme Court," *Catholic University Law Review*, Vol. 23, No. 2 (Winter, 1973), 255-274.

Sklar, June and Beth Berkov. "Abortion, Illegitimacy, and the American Birth Rate," *Science*, Vol. 185 (Sept. 13, 1974), 909-915.

———. "Teenage Illegitimacy: An Exchange" (Letters from Readers), *Family Planning Perspectives*, Vol. 6, No. 3 (Summer, 1974), 134-136.

Stickle, Gabriel and Paul Ma. "Pregnancy in Adolescents: Scope of the Problem," *Contemporary Ob/Gyn* (June, 1975).

Tietze, Christopher. "Legal Abortions in the United States: Rates and Ratios by Race and Age, 1972-1974," *Family Planning Perspectives*, Vol. 9, No. 1 (Jan./Feb., 1977), 12-15.

Vital Statistics of the United States 1972, Vol. 1—Natality. National Center for Health Statistics, HEW.

Weeks, John R. *Teenage Marriages: A Demographic Analysis*. International Population and Urban Research, University of California, Berkeley; Studies in Population and Urban Demography, No. 2. Westport, CT: Greenwood Press, 1976.

Zelnik, Marvin and John F. Kantner. "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971," *Family Planning Perspectives*, Vol. 9, No. 2 March/April, 1977), 55-71.

Reprinted from

RESPECT LIFE PROGRAM 1977/1978
Committee for Pro-Life Activities
National Conference of Catholic Bishops
Washington, D.C.

AMERICAN ACADEMY OF PEDIATRICS

Testimony before the

Interstate and Foreign Commerce Committee
Subcommittee on Health and Environment

Adolescent Health, Services, and Pregnancy
Prevention and Care Act of 1978
H.R. 12146

The American Academy of Pediatrics, an international medical association and children's advocate representing nearly 20,000 pediatricians dedicated to the care of infants, children and adolescents, wishes to submit the following written testimony for inclusion in the record of hearings held on the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 (H.R. 12146).

The Academy's commitment to adolescents and their health is both profound and long-standing. We believe that the pediatrician is often in the best position not only to introduce infants to quality health care but to retain them in the health care system through their childhood and adolescent years. The trust, confidence and rapport established between patient and physician during that span have obvious beneficial consequences to our country's youth.

We do not consider it necessary to deluge the Subcommittee with facts and figures documenting what is now so often described as an epidemic of adolescent pregnancy. These hearings acknowledge the magnitude of the problem; we must now solve it. We are confident no one will dispute the drastically higher mortality rates for infants born to young, adolescent mothers (less than 16 years of age), who in most cases discontinue their schooling upon becoming pregnant and often suffer irreversible emotional harm, many times joining the welfare ranks. It is indeed disturbing that our health, educational and social service systems have failed to address these adverse consequences of adolescent pregnancy in a satisfactory and comprehensive manner. Federal programs have in the past been unfocused and ill-suited, and this fragmentation of effort has resulted in a system fraught with gaps and inefficiency. With this history in mind, the Academy of Pediatrics applauds the intent of the legislation we are considering today, as well as the Administration's initiative in the area of adolescent pregnancy, as a tentative step in the right direction. It is imperative that services, programs and benefits be better coordinated.

The Academy, while supporting the intent and framework of this bill, views it as somewhat idealistic. The bill does address the significant weakness of existing services to adolescents, i.e., the lack of coordination and linkages between primary services and specialized secondary levels of care for the many medical, psychological, social and developmental problems of the age group. But a systems analysis of newly

designed programs must occur in order to achieve an integrated network of services rather than isolated programs unattached to either primary or secondary sources of care, as the case may be. It is also our firm belief that this bill's success hinges on delivery of services by persons specially trained in adolescent care, whether it be medical, nutritional or counseling in sexual or vocational education. Demonstrated competence in adolescent care by those delivering services under the bill's provisions is the key--and we cannot overemphasize the importance of the word "demonstrated." In order to insure that services delivered under the Act's provisions be by specially trained and qualified persons, we would suggest a specific clause be included in the Act directing that federal implementing guidelines require adequate levels of training in adolescent care for those delivering services.

At the same time, we are faced with a critical shortage of just the type of person needed to deliver adolescent care and services. We would urge that the bill's provision for training providers of multidisciplinary services be recognized for what it is--the primary determinant of the bill's chances for successfully addressing the needs of adolescents.

Unfortunately, teen-age pregnancy is characterized by late entry into the prenatal care system. This is especially disturbing since early maternal care is associated with a more favorable outcome for both mother and infant. A critical survey of adverse health consequences of teen-age pregnancy reveals two major complications: preeclampsia-toxemia and an excessive number of low-birth-weight babies. All other potential ill effects of teen-age pregnancy appear to be dependent not on adolescence itself but upon the socio-economic class of the teenager and whether the pregnant teenager has access to a health system.

Low-birth-weight rates from teen-age pregnancy reportedly range from 6 per cent to 20 per cent. Irrespective of socioeconomic class, data from different centers using the gynecological age or the time interval since menarche, rather than chronological age, as a basis of comparison, confirm a higher rate of low-birth-weight infants among young teenagers. Some investigators have found a higher incidence of low birth weight associated with a gynecological age of two years or less.

The higher incidence of low-birth-weight infants and the unfavorable outcome of that phenomenon appear to be the major childbearing hazards facing the pregnant adolescent. Other risk factors associated with teen-age childbearing--socio-economic class, cigarette smoking, alcohol and drug use and improper nutrition--are not age-related but affect all pregnancies. It therefore appears that the biology of adolescence contributes only minimally to the health-associated risks of teen-age childbearing. Different data sources do, however, suggest an association between adolescent childbearing and behavioral or physical problems in infants born to young adolescents:

- Children born to adolescent mothers have a notably higher incidence of childhood mortality, apparently in association with a higher rate of childhood accidents.

- One Canadian study concluded that adolescent mothers were more likely to have handicapped children.

- Another study reported that 11 per cent of children born to girls less than 16 years of age scored less than 70 on I.Q. tests at age 4 compared to 2.6 per cent for the general population.

- This same study noted that school failure and behavioral problems were also more prevalent in children born to young adolescents.

- Other reports link increased child abuse and neglect, deliquent behavior and early pregnancies to the population born to young teens.

The pregnant adolescent is also subject to several unfavorable psychosocial hazards. She is usually economically dependent, is forced to interrupt her schooling and has not had sufficient time to complete the developmental tasks of adolescence. The father of her baby often deserts her, and considering the anger engendered in the family by an unexpected pregnancy in a young unmarried daughter, it is apparent that these girls bear an awesome social burden. The postponement of teen-age childbearing would result in improvement in almost all these adverse reactions in both the adolescent mother and her baby.

Some teen-age mothers will encounter little difficulty in their pregnancies, and their children will develop normally. Nonetheless, the younger the mother, the greater the risk of health-associated consequences of pregnancy, low birth weight and subsequent abnormal child development. Delaying the first pregnancy until the late teen-age years or early 20's substantially diminishes these risks.

Hence, for the young adolescent it is apparent that the burden of pregnancy and implications of having a baby, wanted or unwanted, can result in tremendous liabilities for both her and her child. Regardless of whether the fetus is carried to term or the pregnancy is terminated, comprehensive programs and services must be easily accessible and directed to adolescents if they are to become an integral part of and a contributer to society.

Before addressing possible solutions to the "crisis" situation surrounding pregnant adolescents, we must project ourselves to the desired outcome of programs designed to meet the needs of this population. While reducing infant mortality and salvaging pregnancy are noteworthy goals, as pediatricians we are more interested in the quality of the lives that are preserved--quality for both mother and child. We certainly do not expect all young, pregnant adolescents to elect to remain in the school system or to demonstrate a reduced frequency of low-birth-weight infants. Nor can we presume to identify what constitutes a satisfactory outcome of a young teen-age pregnancy. However, we strongly believe that constructive programs will contribute significantly to the societal adjustment of the adolescent and her child and to the overall quality of their lives. We can do no less for this growing, at-risk population.

The Academy believes this bill's emphasis on linkage of adolescent health care services rather than on the problem of adolescent pregnancy itself is both appropriate and long overdue. The bill's very title recognizes the importance of this approach. For too long we have been concerned with the problem itself instead of its causes and effects. Adolescent pregnancy will not disappear as a social problem next year or in the foreseeable future, so it is appropriate that we direct ourselves to the total spectrum of health care and social adjustment of this segment of our population.

In this regard, the Academy would specifically commend several of the bill's provisions:

- Addressing primary pregnancy prevention in young adolescents, whether it be for initial or repeat pregnancies.

- Linking sexual, parenting and vocational education with other services offered. We would caution, however, that to be effective, those educational programs must be tailored to meet the special needs of adolescents and directed toward understanding sexuality and fostering responsible sexual behavior.

- Stressing coordination of federal policies and programs providing services related to prevention of initial and repeat adolescent pregnancies. We would recommend special emphasis be given to coordination of Title X of the Public Health Service Act and Title V of the Social Security Act, thereby facilitating monitoring of referral and follow-up services and improving continuity of care. Services for maternal and child health under Title V would seem to be an especially appropriate target for this bill's intent to link its services with those already in place.

- Providing training to providers of adolescent services under the Act. As pointed out earlier, this is a key area. Only those with demonstrated competence in the area of adolescent health services should provide those services. Otherwise, the success of the entire program could be jeopardized.

We do, of course, have other concerns which we feel merit attention if this adolescent pregnancy initiative is to be successful. It would be appropriate and constructive to include in Section 102(6)(b) among the types of services to be linked under the program, "adoption and foster care counseling and day-care services." Without these additions, which were recommended in the Joseph P. Kennedy, Jr., Foundation's "Essential Components in a Comprehensive Adolescent Pregnancy Center," the spectrum of care offered is incomplete.

We also consider it necessary that counseling and supportive services be available for adolescents choosing to carry their baby to term as well as for those choosing to terminate their pregnancy. The Academy's philosophy is that all children should be wanted and born to healthy mothers. If unwanted pregnancy occurs, or if there is evidence of

32-704 O - 78 - 14

abnormality or genetic defect of the fetus, consultation should be obtained. Alternatives should include acceptance of parental responsibility for the child, adoption or termination of pregnancy. Furthermore, low income should not deprive an individual of any of these alternatives.

The Academy would also suggest that the Act encourage but not require parental consent for services. A model act for consent of minors for health services is attached as Appendix A.

The Academy considers it particularly appropriate that when this bill was introduced in the Senate, confidentiality of medical records was identified as a topic that this bill should certainly address. We agree wholeheartedly. The Academy considers several points essential for any future confidentiality of medical records legislation: medical records should be a collaborative effort between patient and physician, the patient should own his medical record, physicians should be permitted to maintain fully privileged working notes, medical record release should be negotiated between the patient and third parties, confidences of parents and minors should be separately maintained and periodic review and expungement of medical records should be required. Should the Subcommittee elect to incorporate confidentiality provisions in this bill and require more detailed analysis of the issue, we stand ready to provide that analysis.

In conclusion, we feel that we must speak out against the bill's limited scope. We are aware of the fiscal restraints under which you must work, yet we fear for those geographic areas which have no services in place to link to services provided under this Act. Are we going to deny these areas new services simply because of present dificiencies? Are we going to compound an existing problem with eligibility requirements that many areas of our country will find difficult to meet? At the same time, the Academy of Pediatrics finds much to be commended in the bill despite its limits of scope. We subscribe to the philosophy that linkage of prenatal, intra-partum and post-natal services is the only appropriate way to address the problem of serving our adolescent population. With these linkages should come greater interdisciplinary collaboration (e.g., among pediatricians and obstetricians-gynecologists) and a more unified approach to the delivery of services.

APPENDIX A

AMERICAN ACADEMY OF PEDIATRICS

COMMITTEE ON YOUTH

A MODEL ACT PROVIDING FOR CONSENT OF MINORS FOR HEALTH SERVICES

PREFATORY NOTE*

This Model Act is drafted with the purpose of stimulating all states of the union to review their statutes in regard to minors' consent for health services. It intends to be all inclusive to give the individual state the option to adopt part or all of this Act whenever it sees fit.

In a democratic nation such as ours, individuals' rights are paramount. In order for everyone, including minors, to have the right of obtaining health services, the balance of this right against others becomes of the utmost importance. This Model Act accepts the concept that getting health services is a basic right. Also, it accepts that parents have their basic right of protecting and promoting the health and welfare of their minors. Therefore, this Act is a compromise and a balance of these two basic rights in the conditions specified. The goal of this Act is to insure that all minors can have quality health services by granting the minors self-consent in conditions and instances that will prevent them from seeking services if parental consent is required and by encouraging health professionals to deliver quality services to minors without incurring legal liability. Reasonable safeguards and limitations are stipulated in this Act to protect the minors' safety and the right of the parent. This Act also emphasizes the promotion of family harmony and minor's maturity.

WHEREAS, certain minors are not obtaining adequate medical, dental, or other health care due to current legal and medical obstacles,

Whereas, providers of medical, dental, and other health care are now vulnerable to legal action for giving care to minors,

Whereas, there is a need for coordination, stimulation, and support of access to medical, dental, and other health care for certain minors in need of such care without violating the rights of parents to protect and promote their minors' health,

Be It Enacted by the Legislature of the State of ——, as follows:

Section 1. For the purposes of this act:

(1) "Minor" means any person under the age of majority as defined by the State statute or under 18 years of age, whichever is lower;

(2) "Health Professional" means state licensed physician, psychologist, dentist, osteopathic physician, nurse, and other licensed health practitioner;

(3) "Health Services" means health services specified by the state, appropriately delivered by different health professionals including examination, preventive and curative treatment, operation, hospilization (admission or discharge), giving or receiving blood and blood derivatives, receiving organ transplantation, pledging donation of organs after death, the use of anesthetics, and receiving contraceptive advice and devices;

(4) The masculine shall include the feminine.

Section 2. Any person who reaches the age of majority or 18 years of age or is on active duty with or has served in any branch of the Armed Forces of the United States shall be considered an adult in so far as the consent for health services is concerned.

* This Model Act has been approved by the Council on Child Health of the Academy. It is recommended for enactment in all the states.

Section 3. Notwithstanding any other provision of law, the following minors may give consent to health professionals for health services:

(1) Any minor who is or was ever married, or has had a child, or graduated from high school, or is emancipated; or

(2) Any minor who has been separated form his parent, parents, or legal guardian for whatever reason and is supporting himself by whatever means; or

(3) Any minor who professes or is found to be pregnant, or afflicted with any reportable communicable disease including venereal disease, or drug and substance abuse including alcohol and nicotine. This self-consent only applies to the prevention, diagnosis, and treatment of those conditions specified in this subsection. The self-consent in the case of pregnancy, venereal disease, and drug and substance abuse also obliges the health professional, if he accepts the responsibility as the provider of the health service, to counsel the minor by himself or by referral to another health professional for counselling.

The health professional may, but shall not be obliged to inform the parent, parents, or legal guardian of the minor of any treatment given or needed when:

(a) in the judgment of the health professional severe complications are present or anticipated; or

(b) major surgery or prolonged hospitalization is needed; or

(c) failure to inform the parent, parents, or legal guardian would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public; or

(d) to inform them would benefit the minor's physical and mental health and family harmony.

Such information shall be given to the minor's parent, parents, or legal guardian only when the minor consents or when because of the minor's age or condition the attending health professional can reasonably presume such consent.

Notification or disclosure to the spouse, parent, parents, or legal guardian by the health professional shall not constitute libel or slander, a violation of the right of privacy, a violation of the rule of privileged communication or any other legal basis of liability. When the minor is found not to be pregnant, or not afflicted with venereal disease, or not suffering from a drug or substance abuse, including alcohol and nicotine, then no information with respect to any appointment, examination, test, or other health procedure shall be given to the parent, parents, or legal guardian, if they have not been already informed as permitted in this Act, without the consent of the minor.

(4) Any minor who has physical or emotional problems and is capable of making rational decisions, and whose relationship with his parents or legal guardian is in such a state that by informing them the minor will fail to seek initial or future help. After the professional establishes his rapport with the minor, then he may inform the parent, parents, or legal guardian unless such action will jeopardize the life of the patient or the favorable result of the treatment; or

(5) Any minor who needs emergency care, including transfusions, without which his health will be jeopardized. The parent, parents, or legal guardian shall be informed as soon as practical except in conditions mentioned in subsections 1, 2, 3, or 4 of this section; or

(6) Any minor who has had a child may give effective consent to health service for his child; or

(7) Any minor may give consent for health care for his spouse if his spouse is unable to give consent by reason of physical or mental incapacity.

Section 4. No consent of anyone else including parent, parents, custodian, legal guardian, or any court shall be required for any person mentioned in Section 3 except where specified. Consent of the minor shall not be subject to later disaffirmance or revocation because of minority. The spouse, parent, parents, or legal guardian shall not be liable for payment for such service unless the spouse, parent, parents, or legal

guardian have expressly agreed to pay for such care. The minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services except those who are proven unable to pay and who receive the services in public institutions.

Section 5. If major surgery, general anesthesia, or a life-threatening procedure has to be undertaken on a minor with his consent, it shall be necessary for the physician to obtain approval from another physician for the management except in an emergency in a community where it is impossible for the surgeon to contact any other physician within a reasonable time for the purpose of concurrence.

Section 6. Self-consent of minors shall not apply to sterilization or abortion.

Section 7. No consent shall be required of any minor who does not possess the mental capacity or who has a physical disability which renders him incapable of giving his consent and who has no known relatives or legal guardians if two physicians agree on the health service to be given.

Section 8. Except by specific legal requirement, no information in regard to venereal disease, drug and substance abuse, pregnancy, and emotional illness shall be given by the health professional to another professional, school, law enforcement official, court authority, government agent, spouse, future spouse, employer, or any other person without the consent of the minor, unless giving the information is necessary to the health of the minor and the public and only when the minor's indentity is kept confidential.

Section 9. The consent of the minor who represents that he may give effective consent under this Act for the purpose of receiving health services but who may not in fact do so, shall be deemed effective for the purposes of prevention, diagnosis, and treatment required without the consent of the minor's parent, parents, or legal guardian if the person rendering the service relied in good faith upon the representation of the minor.

Section 10. Any health professional may render or attempt to render emergency service or first aid, medical, surgical, dental, or psychiatric treatment without compensation to any injured person or any person regardless of age who is in need of immediate health care when, in good faith, the professional believes that the giving of aid is the only alternative to probable death or serious physical or mental damage. For major surgery or any dangerous procedures concurrence of another physician shall, if practical, be obtained.

Section 11. Any health professional may render nonemergency services to minors for conditions which will endanger the health or life of the minor if services would be delayed by obtaining consent from spouse, parent, parents, or legal guardian.

Section 12. Any minor who is examined, treated, hospitalized, or receives health services under this Act may give legal consent, and no person who administers such health services shall be liable civilly or criminally for assault, battery, or assault and battery, or any other legal charge, except for negligence or intentional harm, for treating such minor without advising his parent, parents, or legal guardian.

Section 13. In the event of emergency, either parent or legal guardian may authorize by writing or by telephonic communication with a witness any adult to give consent for a minor who himself is unable to give self-consent for health care for whatever reason.

Section 14. Nothing in this Act shall require any health professional to provide service, nor shall any health professional be liable for such refusal.

Section 15. The Governor shall appoint an Advisory Committee that shall have the responsibility of promoting and encouraging the availability of health services for minors; shall conduct and develop resources of payment, private or public, for the rendering of such services; and shall recommend regulations to carry out the conditions and purposes of this Act.

Section 16. In the event any section, sentence, clause, or provision of this Act shall

be declared invalid by any court of competent jurisdiction, such action shall not affect the validity of the remaining sections, sentences, clauses, or provisions of this Act which shall continue effective.

Section 17. This Act shall become effective immediately upon passage and approval of the Governor.

COMMITTEE ON YOUTH

SPRAGUE W. HAZARD, M.D., *Chairman*
V. ROBERT ALLEN, M.D.
VICTOR EISNER, M.D.
DALE C. GARELL, M.D.
S. L. HAMMAR, M.D.
THOMAS E. SHAFFER, M.D.
JEROME T. Y. SHEN, M.D., Editor
NATALIA M. TANNER, M.D.
JOHN ALLEN WELTY, M.D.

Reprinted from *Pediatrics*, Vol. 51, No. 2
February, 1973
© All rights reserved

Statement by Clyde E. Shorey, Jr
Vice President for Public Affairs
The National Foundation-March of Dimes
on H.R. 12146
Adolescent Health, Services and Pregnancy
Prevention and Care Act of 1978

The goal of the March of Dimes is to prevent birth defects and improve the outcome of pregnancy. To meet this goal we urge that every action be taken to meet the critical health risks to mother and infant that are too often the tragic results of adolescent pregnancy.

The March of Dimes supports the concepts of H.R. 12146.

1. We believe strongly in the need for a coordinating or linking role to see that the necessary services are brought together and are available to teenagers before and after the onset of pregnancy. This bill should concentrate on that role and the part the federal government plays in it.
2. We do not believe that this Bill should seek to fund the major part of teenage pregnancy. Such funds should come from established sources - federal, state and local. However, funds should be available for seed money or start up costs to get new services underway.
3. We recommend that the Bill provide for the development of educational materials and the training of educators as well as providers of services by organizations with some established expertise.

4. We recommend that the Bill provide:

   a. For an advisory committee to consult with the Secretary on the issuance of regulations for the program and to participate in an evaluation after several years of operation.

   b. Requirements for maintenance of effort by states and local government.

You have heard testimony concerning prevention as applied to H.R.12146-that is preventing the pregnancy from occuring. I would ask you to focus for a few moments on one of the principal beneficiaries of this Bill, the unborn and newborn infant. With the focus on the infant, prevention takes on a new meaning and applies to the most important preventive health care in any person's life - prenatal and immediate postnatal care.

Birth defects are the nation's major child health problem. Some quarter-million infants are affected every year by mental or physical handicaps that deny them an equal chance to live full, productive lives. Many of these infants die before their first birthday.

Adolescents bear nearly 600,000 babies each year - one-fifth of the nation's births. Half are illegitimate. The youngest of these teenagers, 17 and under, have the highest rate of any age group of dead or damaged babies.

Low birthweight, our most common birth defect, is prevalent among babies of teenage mothers and substantially greater as a percentage of births than at any other age. Low birthweight is the cause of the greatest number of deaths in the first year of life, and the major cause of disability in childhood. Brain damage

or learning disabilities, often accompanied by emotional and behavioral problems, and structural defects can be a lifetime burden for a baby born too small or too soon.

While prenatal care is not the only influence on birthweight, its importance is obvious wherever data on the outcome of pregnancy have been examined. The results were especially revealing for teenage mothers. A study in New York City showed that among teenagers whose pregnancies were not at either social or medical risk, low weight ratios varied from 5.5 percent for those who began care in the first trimester, to 8.5 percent when care started in the second and third trimesters, to 9.9 percent for mothers who had no prenatal care at all. Among teenage mothers with high risk pregnancies, the low weight ratios also reflected the influence of prenatal care, varying from 15.4 percent of births for those whose medical care began in the first trimester, to 23.1 percent among mothers who had no care at all.

It is primarily the lack of early, continuous prenatal care including adequate nutrition that results in the higher incidence among mothers of this age group of iron-deficiency anemia, hypertension, toxemia, and premature or prolonged labor. In turn, these conditions threaten her baby with greater incidence of mental retardation, physical malformations, and early infant death.

In 1975, some 280,000 teenage mothers in this country either had late prenatal care or had no care at all during pregnancy.

Shame, fear of parental reaction, lack of knowledge of where to get services, lack of funds, or the simple fact that a young girl does not realize she is having a baby, are common reasons

why she does not seek medical help early enough. The relationship between prenatal care and maternal/infant health has been amply demonstrated.

While prenatal health care is only one part of the total services to be brought together by this Bill, it is one of major importance. It must be coordinated with the other services for maximum effect particularly for the newborn infant. Even though the major focus of the March of Dimes is the health of the newborn, we are fully aware that the full range of social, economic and educational services must be brought together for mother and child to assure the newborn any kind of a decent start in life. For this child, a life begun in poverty often continues in poverty and a cruel cycle is perpetuated.

Because of the devastating effects that teenage pregnancy can have on young lives, the March of Dimes has given top priority to the problem of "children having children". Together with national and local leaders in the health, educational and social service fields, we are working to change this dilemma that denies society the potential strengths of these mothers and babies.

Throughout its network of chapters, March of Dimes representatives --staff and volunteers-- collaborate with other organizations in focusing public attention on the concerns of adolescent pregnancy. To stimulate development and expansion of programs fitting community needs, the March of Dimes, as part of this collaboration, has funded health education and prenatal care grants in recent years in an effort to bring together and coordinate services to the high-risk pregnant teenager.

Here are some examples:

A comprehensive teenage obstetrical program at Truman Medical Center, in Kansas City, Missouri;

Salaries and travel assistance for a nurse educator and health educator at the Student-Parent Center for Infants in Ann Arbor, Michigan;

Salary assistance for personnel to conduct a health education program for pregnant students in the School District of Pontiac, Michigan;

Providing salary for a registered nurse to work as health educator with the Young Mothers Program of the San Jose Unified School District in California;

Enabling the Montgomery County Health District, in Dayton, Ohio, to provide maternal health service to adolescents through counseling and teaching. Program emphasis has been on prenatal care, good nutrition, and an understanding of the adolescent's role as a mother in caring for her child's mental, social and physical growth.

Assisting a bilingual health education program for non-pregnant, pregnant, and newly delivered Spanish-speaking teenagers at the Martin Luther King, Jr. General Hospital, in Los Angeles;

Conducting a comprehensive school-age parent education program at Boston Hospital for Women. This is a multidisciplinary, demonstration program in counseling, medical care, day care, and parenting/consumer education;

Defraying salary costs for the Appalachian District Health Department, in Boone, North Carolina, for educational and supportive services in a six-county area;

Salary allocation to Methodist Hospital of Gary, Indiana, for a nurse educator to develop and teach prenatal care courses;

Defraying salary costs of a nurse-educator at Baroness Erlanger Hospital in Chattanooga, Tennessee, serving an obstetrical clinic with many teenage patients;

Providing assistance to the Bradley-Cleveland Community Services Agency in Cleveland, Tennessee, for prenatal care and parenting instruction;

Offering health care, schooling and counseling services at the Margaret Hudson Program for School-Age Parents in Tulsa, Oklahoma;

Providing a grant to Brooklyn Jewish Hospital in New York City for a family health worker at a neighborhood center;

Providing a grant to assist in education for school-age mothers and fathers at the New Futures School in Albuquerque, New Mexico. New Futures provides a broad range of services to adolescent parents throughout the state.

In each instance the March of Dimes grant provided the essential element that made it possible for existing services to expand to cover more of the teenage pregnancy requirements of that community. These grants were made in all types of communities, large and small, urban and rural. The March of Dimes has demonstrated that, with small seed money grants, services can be expanded and coordinated in most any community. We believe that through H.R. 12146 the federal government can accomplish this same objective on a nationwide basis.

We also believe we have demonstrated that someone must take the initiative to see that this coordination of services gets started in each community. It is essential that local governmental units be brought into the planning and funding of appropriate services. In Columbus, Ohio, the March of Dimes Chapter through a small grant and

the marshalling of community concern secured the support of the City of Columbus and the Board of Education for a special program for pregnant adolescents at the Bethune Center. The Center provides, or makes referral to, a full range of comprehensive services as proposed in this Bill.

While we will continue to seek to play a similar role in as many communities as possible, we believe that the role of federal government should be to see that the coordination process is initiated in every community. The federal role need not be involved in working out the detailed plan but should see that the process gets started and have the responsibility to monitor progress toward the establishment and implementation of a plan. We do not believe that the total responsibility for starting the program should be left to the initiative of others.

You have already heard testimony urging you not to consider H.R. 12146 as the principal source for funding of services. This was specifically referred to with regard to family planning services where the major funding comes from Title X of the Public Health Service Act. We believe this should apply to substantially all other services as well. Maternal and child health services, including prenatal and newborn care, are primarily funded from Medicaid, EPSDT, Title V of the Social Security Act and Community Health Centers as well as various state programs. In order to provide the funding for prenatal and immediate postnatal care to teenage mothers it is much more important for Congress to adopt the amendment to Medicaid as proposed in the President's Budget allocating $118 million for prenatal and postnatal care for all low income women. Such an

amendment to the Medicaid Act is currently being considered in the House of Representatives and should go to the Senate in the near future. It is estimated that of the $118 million, $18 million would apply to services for teenagers. We urge the Senate to pass such an amendment to Medicaid.

The importance of H.R. 12146 is its coordination function. It should be used primarily for this purpose with sufficient funds available for seed money or start up costs where they are particularly useful in bringing services together to focus on the teenage problem. We believe that sufficient funds should be used to assure the exercise of the federal role to see that the coordination process is carried out in every community. However, in order to be able to pay start up costs for certain new services which may amount to more than 50 percent of those particular services, we urge the deletion of the words "any part of" in Section 102(e).

One element that appears to be overlooked in the Bill is the development of materials for, and the training of, educators as well as providers of services for adolescents. One of the most important roles we believe the March of Dimes has had to play in seeking to have a positive effect on the problem has been the development of teaching materials and guides and the sponsorship of in-service training programs for educators and other providers.

Some examples are:

Collaboration with the Center for the Family of the American Home Economics Association and the funding of teams of university teachers in family life education, nutrition, and child growth and development. These teams worked with schools and colleges in their

regions to upgrade studies in these fields. We also funded a curriculua reader on family life education for grades 5 through 12;

Sponsored in New York City 9 weekly and in metropolitan Chicago 13 weekly in-service training programs for elementary and high school teachers on Parenting Priorities;

Cosponsored with the Junior League and the PTA in Topeka, Kansas and with the Junior League in Boston conferences for providers of services to pregnant teenagers.

Of major importance, and now with national scope, is the joint collaboration between the March of Dimes and The National Congress of Parents and Teachers entitled, "Parenting - PTA Priority". The March of Dimes has funded 17 regional conferences which reached all 50 states and our troops in Europe. The goal of this program is to strengthen family life by upgrading preparenthood education in elementary and secondary schools. Each conference involved teams of parent leaders, school administrators, teachers and school nurses. The subject matter covers many parts of a comprehensive program - maternal and infant health care, nutrition, genetics, family life education, parenting skills and responsibilities, and educational techniques. The success of the regional conferences has now led to a series of metropolitan conferences in many of the major cities.

The March of Dimes has sponsored and funded the development of two sets of special educational materials particularly applicable to teenagers that can be incorporated into the school curriculum. One, prepared by Bank Street College of Education in New York City, focuses on maternal health care and nutrition in pregnancy. The other, prepared by Educational Development Center of Cambridge,

Massachusetts, covers adolescent sexuality and choices about pregnancy, the experience of pregnancy and parenthood, responsibilities of parenthood, and birth defects and their impact on parents and society. While both are brand new they have been received by the educational community with great enthusiasm.

It is especially important to point out that the Educational Development Center materials apply both to the problems of primary prevention of pregnancy as well as to the problems of preventive health care for the teenage mother and her baby. It is our belief that education at the proper time and through appropriate techniques relating to sexuality, pregnancy, and responsibilities of parenthood can have an important impact on reducing the number of pregnancies among teenagers.

We recommend that this Bill, H.R. 12146, provide for the development of new educational materials, the utilization of existing educational materials such as those developed by the March of Dimes and others and the training of educators as well as service providers in appropriate techniques for dealing with the problems of adolescent pregnancy. The restrictions of Section 102(a)(6) should not be so broad as to prevent the utilization of materials and provision of training to educators and providers by organizations such as the PTA, American Home Economics Association, Bank Street College of Education, Educational Development Center or the March of Dimes.

We wish to support recommendations made by others that the Bill provide for an advisory committee of professionals, and representatives of the teenagers, state and local governmental units and voluntary organizations, who have competence through training and experience to make recommendations to the Secretary on the administration of the

program. These recommendations should specifically be directed to, among others, the issuance of regulations and the evaluation process.

We also support the recommendation for maintenance of effort by state and local governments. This is the only way that Section 103 (a)(5), requiring the program to make use of all other available funds, including state and local funds, can be effective. Maintenance of effort is essential if the federal role is to be primarily one of coordination and seeking to develop new programs from other federal, state and local sources and existing community institutions.

The March of Dimes supports the basic concepts of H.R. 12146. We believe that passage of such a bill with the recommendations we have suggested may be the best way to launch a nationwide attack on the problems of teenage pregnancy. We urge your support.

I wish to thank the Committee for the opportunity to present this statement on behalf of the March of Dimes.

32-704 O - 78 - 15

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE
720 RUTLAND AVENUE
BALTIMORE, MARYLAND 21205

OFFICE OF CONTINUING EDUCATION
TURNER AUDITORIUM BUILDING

CABLE ADDRESS
HOPMED

June 27, 1978

Congressman Paul Rogers
2415 Raburn House Office Building
Washington, D.C. 20515

Dear Mr. Rogers:

I would be most appreciative if my written testimony on Senate Bill 2910 could be entered into the testimony pertaining to the hearings (June 28, 1978) on the Administrations Adolescent Pregnancy Prevention and Care Act of 1978, before your committee on Health and the Environment.

I feel strongly that adolescent pregnancy is a serious national problem. Prevention, while highly desirable, is not a sufficient answer for the adolescent.

Many thanks.

Sincerely,

Janet B. Hardy, M.D.
Professor of Pediatrics

JBH:cmk

Attachment

Testimony on Senate Bill 2910

Presentation to the Committee on Human Resources

Gentlemen:

May I thank you for permitting me to testify in support of the Administration's Initiative in Adolescent Pregnancy. This is a matter of great concern to me and one with which I have had considerable experience. My testimony will touch briefly on three areas:

(1) the National scope of the problem

(2) the research findings of the Johns Hopkins group

(3) proposed solutions to the problem.

First, let me qualify myself. I am Professor of Pediatrics in the Johns Hopkins School of Medicine and Professor of Health Services Administration in the Johns Hopkins School of Hygiene and Public Health. For many years, I have been Director of the Johns Hopkins Child Development Study and for the past several years deeply involved in the Johns Hopkins Center for School-Aged Mothers and Their Children. As co-director of the Center, I have had responsibility for overall program development with direct responsibility for the development of the follow-up component.

(1) National Scope of Problem - as the Administration has pointed out, the problem is extensive in terms of numbers involved

and enormously costly to society in terms of money spent for medical care, special education, welfare support and lost productivity. Today, approximately one of every five babies born in the U.S. is born to a teenaged mother. Of the nearly one million teenagers who become pregnant each year, 400,000 are adolescents (i.e., the mother is 17 years or under) and 30,000 are less than 15 years when they give birth. In our experience, a high proportion of these children are unplanned and unwanted. Almost 300,000 elective abortions among teenagers were reported in 1975.

It is toward the problems of adolescent mothers (i.e., 17 years and below) and their children that I wish to direct your attention. They constitute a particularly high risk group and, in my view, should be the target of the Administration's initiative. As this is a considerably smaller group, concentration of new resources and effort should be more productive.

On a national level, the birth rate in all age groups, with the exception of the teenagers, has shown a significant decline over the past decade and, according to recent reports from the National Center for Vital Statistics, the rate for 18 and 19 year olds has also turned down slightly. As sexual activity has increased, this must reflect the availability and use of family planning and elective abortion.

Data from the National Collaborative Perinatal Study (NINCDS) has shown that 18 and 19 year old mothers have the lowest risk of perinatal mortality of any age group. However, the birth rate for adolescents, i.e., 17 years of age and below, has continued to rise.

In my experience, the problems stemming from adolescent pregnancy result from interaction between biological and social factors related, in large part, to the immaturity of the mother. The important contribution of the biological factors tends to be overlooked. The mother is physically immature, and often in her adolescent growth spurt. She is at high risk of complications of pregnancy, labor and delivery, particularly anemia, toxemia of pregnancy and difficult delivery, all of which compromise the fetus, leading to risks of perinatal death and/or later neurological deficits, risks 2 to 3 times greater than those for the children of older women. The high rates of obstetrical complications and of premature delivery among adolescents result in large costs for special medical care for the mothers, intensive neonatal care and in high risks of sub-optimal development in surviving children. Where special programs are not available 90% of adolescents drop out of school, do not complete their education and thus, limit their employment opportunities. ~~She is~~ They are more likely to have more children and greater welfare dependency.

(2) The Johns Hopkins Child Development Study is a longitudinal research study for investigation of factors affecting child development in a large urban population of black and white children and their families. It has been ongoing since 1959. Of the 4800 pregnancies followed from the time of the first prenatal visit until surviving children reached 8 years, 688 were in adolescence, 17 years and below at the time of delivery. Examination of the data shows high risks of complications of pregnancy, low birth weight and perinatal and infant death for these pregnancies. In addition, the surviving children have, on the average, lower IQs and higher rates of school failure than the children of older women. These problems have been documented by others and it is toward new information, pertaining to the outcome for the adolescent mother, 12 years after the birth of her child, that I would call your attention.

The long-range outcome of a group of 77 adolescents 12 years after the birth of their first study child has been compared, along a number of parameters of social well being, with the outcome for a group of primiparous women (20-24 years of age) thought to be in a more optimal age group for successful child bearing.

There is no question that the adolescent mothers in this study were at a serious disadvantage as compared with women in the older

age group with respect to a number of important variables strongly influencing the quality of life and one's ability to successfully nurture one's children.

The young mothers experienced a high degree of family instability, in terms of changes in marital status, as 45% experienced three or more changes during the 12 year period while only one of the older women experienced more than 2 changes and 43% had no change at all.

While maternal educational attainment improved considerably over the 12 years, with the younger mothers, in general, achieving considerably more education after the birth of their study child, than the older mothers, at the end of the 12 year period the adolescents were still far behind, with only 35% having graduated from high school as compared with 77% of the older mothers. Lower educational attainment was paralleled by lower occupational achievement, lower income and greater welfare dependency. At both the seven and twelve year follow-up levels only 44% of the young mothers and their families were fully self-supporting as contrasted with 67% of the older mothers and their families, at the 7 year level and 71% at the 12 year level. The average annual level of social service support in money for these young mothers and their children was $2,147 at the 7 year follow-up

and at the 12 year follow-up it had increased to $2,919, a meager sum from which to provide the resources for a family with an average of 3.25 children. The employment history showed that, on the average, these young women worked slightly less than 20% of the time during the 12 year period, for an average of about 29 months in all.

Increased fertility (47% repeat pregnancies within 1 year and 70% within 3 years), in terms of both live births and fetal deaths undoubtedly complicated the picture for the young mothers, resulting in further taxing of already seriously limited resources, even though public funds through medical assistance provided coverage for medical costs.

It seems likely that having responsibility for rearing a child, frequently without the help of a husband or father, particularly when limited in education and material resources, posed a serious burden which put severe limitations on the educational and employment attainments of these young women. These problems were compounded by the birth of additional children soon after the first, further taxing their resources and ability to cope. An investigation carried out when their study children were 8 years old showed that 70% of these women knew contraception was possible but lacked the basic information needed to control their fertility and to instruct their children about human reproduction.

It is important to emphasize that these differences between the adolescent mothers and those in an older and more favorable age range are based on grouped data and that considerable diversity in outcome actually exists within both the adolescent and control groups. Some adolescent mothers were able to complete their education, develop stable family environments and raise successful children.

(3) Current experience in The Johns Hopkins Center, with a large number of pregnant adolescents and their children strongly suggests that intervention designed to prevent or minimize the mix of biological and environmental problems which relate to adverse outcomes can be highly effective.

(a) Good prenatal care can reduce risks of perinatal death, low birth weight and central nervous system injury;

(b) Supportive psycho-social and educational services during pregnancy, and the hospital stay, can help the young mother deliver a healthy baby and prepare for parenthood;

(c) An ongoing follow-up program can help the young family establish a stable environment for child rearing. Ongoing birth control services, education and supplies can effectively reduce early repeat pregnancy (in our program to 5% within 12 months, 11% within 18 months after the birth of the first child). Individual psycho-social

screening and where needed diagnosis can help young mothers re-enter school or obtain placement in work study programs (87% are back in school after delivery) leading to regular employment. Information about parenting, child development, nutrition, drugs, alcohol, etc. can result in improved adolescent and child health and reduce the risk of child abuse and neglect.

Furthermore, present ongoing research, sponsored by the Office of Child Development, indicates that urban adolescents have, in general, little accurate information about reproduction, contraception, child development and parenting. While difficult to measure, the intervention to supply needed information is not only effective with the adolescent mother, but has a ripple effect extending beyond the adolescent served, providing primary prevention for her siblings and friends, who like herself are vulnerable to adolescent pregnancy and its consequences.

The Johns Hopkins program has several unusual features: (a) fathers are included in the educational program both prenatally and in the Follow-Up where special group discussions on family planning, drugs, child care and other topics are discussed; (b) there are unusually close working relationships with other community agencies including the Baltimore City Departments of Social Services, Education, Health, Recreation, Manpower, Job Corps and private agencies such

as Florence Crittenton. Members of the Center staff serve on advisory committees or boards of these organizations and provide consultant services helping to develop policy in the area of adolescent needs; (c) the young mothers in the group educational sessions are encouraged to help each other; (d) the follow-up period has been extended to 3 years so that support may be available where needed until the child can be entered in Head Start or some other community program for three year olds.

In Summary

The problems stemming from pregnancy in adolescent women are a serious problem. They stem from the physical and psychosocial immaturity which, in many instances, lead to complications of pregnancy and fetal damage on the one hand and to a less than adequate family environment in which to nurture children on the other. Our program strongly suggests that intervention is effective: (1) in preventing or mitigating many of the problems; (2) in helping the adolescent mother to delay future pregnancies, complete her education and to become a contributing member of society.

Finally, why not put all the emphasis on preventing that first adolescent pregnancy? Obviously that is the ideal solution. However, in my experience, it will be many years before we can attain that goal.

Family planning programs, where available, have had considerable success with the 18 and 19 year olds. They have, in general, failed the adolescents. Furthermore, there is no ideal contraceptive for these young people. Effective educational programs stressing family living, values clarification and personal responsibility, child development, parenting and health are desperately needed for all adolescents, boys and girls. Innovative after school programs utilizing the abundant energies of adolescents are needed as alternative activities. To deal with the urgent current problems of unwanted pregnancy, leadership in mobilizing community resources is a must. This is where the Administration's Initiative can be vitally important in focusing attention and leading the way.

Janet B. Hardy, M. D.
Professor of Pediatrics
Co-Director, Center for
Teenage Mothers and
Their Children

WILLIAM DONALD SCHAEFER, Mayor
OFFICE OF THE MAYOR • CITY OF BALTIMORE
250 City Hall, Baltimore, Maryland 21202, (301) 396-3100

June 29, 1978

In reply refer to: MO-40

The Honorable Paul G. Rogers
Chairman
House Sub-Committee on Health
and Environment
2407 Rayburn House Office Building
Washington, D. C.

Attention: Dr. George Hardy

Dear Mr. Rogers:

The City of Baltimore is pleased to submit to you the attached testimony on the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

As the written testimony indicates, we are gearing up for a major emphasis on adolescent pregnancy prevention, to include a heavy public awareness and education campaign, motivational and attitude change program directed to adolescents, sex education, contraceptive education, and a networking of comprehensive adolescent health care centers.

We enthusiastically endorse and support the proposed legislation currently under consideration by your committee. A number of areas need to be included or strengthened in the legislation, and the written testimony herewith submitted offers suggestions on these desirable additions.

If opportunity allows the presentation of oral testimony at future committee hearings, we would be grateful to appear before your committee to testify on adolescent pregnancy prevention. Our contact person to arrange for such testimony is Mr. Ray Bird, Chief of Human Services Planning, Department of Planning, 222 E. Saratoga St., Baltimore, Maryland 21202. His phone number is 301-396-4367.

Sincerely,

QUENTIN R. LAWSON
Human Resources Coordinator

Enclosure

BALTIMORE

It is with pleasure that we appear before you to address, on behalf of the Mayor of Baltimore City, William Donald Schaefer, the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

Baltimore is the seventh largest city in the United States, an older industrial city that is experiencing the kind of rebirth and rejuvination to which many other cities look with envy. While Baltimore is no more free of problems and challenges then any other older eastern industrial city, it is blessed with creative leadership, sound fiscal policies, a mood of optimism, and an exceptionally beneficial government structure in which the City lies within no county or other government unit except the state, making for an unusually well integrated human services network. With virtually all public human services responsible and responsive to the Mayor, including employment, welfare, housing, education, health, social service, leisure and culture, fire, police, and corrections, a degree of integration of services is possible in Baltimore unthinkable in most major cities.

I say this because Baltimore has recently, apart from any possible impact of the legislation currently receiving your consideration in these hearings here today, turned its attention to the issue of teenage pregnancy. Our approach, as we have sought to develop a strategy to reverse the trend of statistics on adolescent childbearing, has been to develop linkages between all of the relevant agencies which must be mobilized to implement a comprehensive plan integrating education, staff training, community awareness, motivational change, as well as improvement in access to birth control services.

Briefly, our intention and direction has been to create out of many presently separate and disparate elements a single integrated and multi-disciplinary plan of action to address simultaneously the many components of adolescent pregnancy. The initiative and continued guidance for this effort has come from the Office of the Mayor. It is anticipated that adolescent pregnancy prevention, along with parenting education, will be the primary focus of the emerging City Commission on the Family, presently also being formulated by the Mayor's Office.

It is within the context of a major city's commitment to reverse the trend of teenage pregnancy that, on behalf of Mayor Schaefer, I appear before you to comment upon the proposed Senate Bill 2910. The comments here presented will focus first on the strengths of the Bill, then on the specific dimensions of the problem of teenage pregnancy as we witness them in Baltimore, and finally on the additional elements we would like to see included in the Bill to make it even better.

Our most fundamental comment on the Bill is "Thank Heavens!" Thank Heavens, thanks to Senators Kennedy, Williams, Javits, and Hathaway, and all of the multitude of others who have brought the issue this far. For no longer can we hide from this issue; no longer can we hope that childbearing by adolsecents who are hardly more than children themselves will go away if we continue to ignore it. No longer can we afford to ignore the fact that an ever growing proportion of our children arrive uninvited, unplanned, to unprepared adolescent parents.

We strongly applaud the basic direction of this Bill, recognizing as it does the complex and multi-faceted nature of the problem. Prevention of teenage pregnancy requires the effective linkage of many different, yet closely inter-related, services. Better sex education alone will not solve the problem. Better and more accessible adolescent health and birth control clinics alone will not solve the problem. Increased community awareness and concern alone will not solve the problem. These services must be linked together in a truly integrated network in which each actively reinforces the other.

Pregnancy prevention connot be sufficiently achieved by more birth control clinics alone. With solid research evidence showing that the vast majority of teenagers do not use any means of birth control until they have been sexually active for some time, there obviously must be a great deal of effort focused on education and motivation.

We are convinced that it is in the area of education and attitude change that the greatest attention must be focused. Too long have we been reticient to do a really adequate job of sex education. Too long have we allowed fear of those who oppose objective sex education to dictate what we will teach or not teach. Too long have we hoped that what our children and youth do not know about sex will not hurt them. But research proves that what youth do not know about sex does hurt them, and hurt their unintended children.

We applaud the fact that the Bill calls for innovation and testing of new methods of education, motivation, and service delivery. Especially important, in our view, is the development and testing of new techniques of integration and networking of services, outreach, and staff training.

The situation in Baltimore is probably not unlike that of other major cities. We find that while the general birth rate has declined significantly, from 116 births per 1,000 childbearing age women in 1960 to 58 births per 1,000 women in 1976 (a 50% reduction in 16 years), the birth rates for teenagers have not shown parallel declines. The general birthrate for women 15 to 19 declined by 38 percent from 120 births per 1,000 15 - 19 years old women in 1960 to 74 per 1,000 in 1976. The rate for black women 15 to 19 however, declined by 53 percent, from 181 births per 1,000 black 15 - 19 year olds in 1960 to 86 per 1,000 in 1976. The rate for white 15 to 19 year olds showed a much smaller decline of only 37 percent, from 82 per 1,000 in 1960 to 52 per 1,000 in 1976. The most distrubing data, however, relates to birth rates for young women 10 to 14 years of age. From 1960 to 1976 the rate of births to 10 to 14 year olds shows no decline at all, resulting from the balancing of a 39 percent decrease in births among black 10 - 14 years olds and a 140 percent increase in births to 10 - 14 year old whites.

Clearly, the most disturbing and difficult problem is among younger adolescents age 14 and under, and with young white girls specifically, among whom the birthrate is increasing dramatically.

The major dimension of the problem, however, is that while all birthrates (except 10-14 whites) are declining, teenage birthrates are declining less rapidly then birthrates among older women, resulting in a greater proportion of our children being unintentionally born to teenagers who are unprepared for parenthood, unprepared for life, unprepared to support and nuture children while they are still children themselves. In 1960 in Baltimore, 22 percent of all live births were to women 19 and under. By 1976, 30 percent of all live births were to teenage mothers.

32-704 O - 78 - 16

The final critical dimension of the situation as we see it in Baltimore concerns the numbers of women having repeat pregnancies while still in their teenage years. In 1976, over 1,100 teenagers had a second, third, or fourth child; 336 age 17 or under had a second, third, or fourth child.

Since a number of studies have conclusively shown that a second birth to a teenager makes continued education and/or job training virtually impossible, one of our greatest priorities is to reach the young woman who has already borne one child and do everthing possible to encourage and assist her to complete her education and become economically self sufficient before she has another child.

In light of our concern, commitment, and the current situation in Baltimore, there are a number of suggestions we would like to present that, in our view, would significantly strengthen the Bill.

First, a component of pregnancy prevention which we find totally missing from the Bill is the fostering and development of healthy and positive self-image among adolescents. We strongly believe that an effective program of pregnancy prevention must look more at the underlying motivations than merely at the surface manifestations. Our review of the best research literature on adolescent pregnancy and adolescent development indicates to us that much of the motivation for early childbearing, albeit often unconscious, is the desire for status and role clarification that (it is thought) parenthood confers. It must seem to many young people in our society, especially at the lower economic end of society, that their most significant status comes from the simple biological function of producing children. For if a young woman has no vision of

herself and her future that is loftier than her parents knew, if she has no expectations of life that a baby will seriously interrupt, then she has little motivation to resist sexual activity or to prevent impregnation. Likewise if young men have no visions of their future that provide them with an inner sense of worth and value, if they have no expectations of life that the responsibilities of child support will inhibit, if they have no respect for the worth and value of their female peers other than as sexual objects, then "scoring" with the young women and impregnating them become their chief source of a feeling of importance and status. But how tragic that we should be raising young adults whose self-images are so vacuous that adolescent childbearing is their chief source of status and worth; how tragic to be raising a generation whose sense of the future is so empty that a severe reduction of educational and career opportunities as a result of teenage childbearing seems to be no loss; how tragic that we are raising a generation of young adults who do not have a vision of their future that is exciting and enticing enough to make pregnancy prevention a high priority for them.

If we would truly seek to have our adolescents avoid early and untimely pregnancies, then we must deal seriously with their need to be encouraged to develop and pursue concepts of self-worth and future opportunities. A sense of self-worth and optimism about their futures will provide them with the motivations to avoid the pregnancies which would diminish their future opportunities and stunt their possibilities. If we are serious about teenage pregnancy prevention we cannot afford to neglect the matter of the adolescents' self-images.

Second, an absolutely critical area that must be added would focus concern and services on the very young teenagers. We must mount an effort that will dramatically reduce pregnancy in the 12, 13, 14 and 15 year old population. Few things in life are so tragic or absurd as a 12 or 13 year old child having a child. Yet it is this age group that we are failing to reach with any of the current preventive efforts. It is the very young teenagers whose birthrates are staying stable or even increasing. It is the very young teenager who is generally exempt from what sex and contraceptive education programs as do exist. It is the very young teenager who has so little concept of the future and his or her place in the future that there is little motivation to avoid pregnancy. It is the very young teenager who has least access to such birth control services as do exist. It is the very young teenager who most lacks both the knowledge and motivation to utilize birth control or to refrain from sexual activity. It is the very young teenager for whom we do the least by way of pregnancy prevention, but for whom pregnancy is the greatest tragedy.

Third, the Bill should contain much greater recognition of the need to support and strengthen already existing programs that are well established and successful given their limited resources. In an era of shrinking resources we cannot afford to assume that existing programs have adequate support or are doing all that they are capable of accomplishing. We find, for example, that valuable and proven services are often withering for lack of adequate financial support, especially as constant level funding is rapidly eroded by inflation.

Fourth, it needs to be recognized even more than the present Bill seems to do, that pregnancy prevention is much, much more than birth control services. Birth control services are the easy part; what is more difficult and must come first is the educational and motivational components which will assist youth in making responsible and conscious decisions about their own sexuality, whether or not they want to be sexually active, how to deal with sexual pressures, and how to be responsible in their sexual relationships. Thus, while the health services component is important, it is not the entire package of pregnancy prevention, nor necessarily even the central component.

To the extent that health services are important, however, the focus should be clearly and emphatically on establishment of a continuity of care rather than clinics that deliver primarily crisis care. In the pregnancy prevention system that Baltimore is attempting to develop, for example, we are looking to the hospitals, primary care centers, and health maintenance organizations to develop a city-wide network of comprehensive adolescent health care programs that are integrated into the health and sex education programs of the schools and other community institutions for purposes of outreach. We aim to involve adolescents in regular and continuous health care in which birth control is only one element delivered on an as needed basis in the context of total health care.

Fifth, although we emphatically believe that this Bill must be and remain primarily focused on primary prevention, a very important element of prevention must address the needs of the young parents who have already borne one child but could, with adequate support and assistance, refrain from further childbearing until their education and career preparation is completed. If we dare not be so shortsighted as to deal only with the already pregnant and already parents, neither dare we ignore the critical position of the adolescent who is already a parent. Adolescent parents are often in desparate need of counseling, educational or vocational training assistance, housing, and other supportive services. With greater assistance, adolescents who are already parents can be helped to keep an impediment to their development from becoming the one-way street to poverty and dependence it has traditionally been.

Sixth, we recommend that the Bill be amended to contain a very strong component dealing with community education and awareness of teenage pregnancy. For it is lack of adult society's acceptance of adolescent sexuality and willingness to deal with the fact that teenagers are sexually mature that is much of the reason why adolescents themselves are so reticent to admit their own sexuality and deal with it responsibly.

Finally, we feel that the Bill needs to much more emphatically and specifically focus its emphasis on <u>primary</u> prevention of teenage pregnancy. All too often programs that are supposed to be preventive end up focusing on those who already have the problem. Pregnancy prevention which focuses only on young women who are already pregnant will end up as a farce. What is desperately needed is a major initiative which will dramatically improve our programs of sex education, contraceptive education,

community understanding, parental effectiveness, access to birth control services, and the motivations and values of adolescents. The fact of adolescent sexuality must be brought out of the closet. Children and youth must be taught the facts of sex, birth control, and techniques of responsible decision-making. Parents must be taught that more rather than less open discussion with children about sex prevents pregnancy. Teachers, counselors, health professionals, recreation leaders, as well as parents, need instruction in how to effectively discuss sexuality with children and youth. All of this needs to be done before our young women become pregnant.

Teenage pregnancy is a problem we cannot afford to ignore. We cannot afford to have the life opportunities of our young women stunted. We cannot afford to have an ever increasing proportion of our children born into families that are unprepared for them and unable to provide the best of nuturance and support. We can and must do better.

On behalf of the Mayor and Baltimore City we applaud this Bill before you today, and urge it be made even better and receive the full support of this Committee.

As Kenneth Keniston and the Carniege Council on Children have written:

> Our society needs the best adults we can make, adults who are caring, resourceful, moral, whole, and physically healthy. When we fail to support the development of the next generation and of the families that nurture them we deprive ourselves and the nation of a part of our children's potential. Children who lose a sense of a decent future are likely to become dispirited, angry, withdrawn, and outraged. (All Our Children, pp. 215-16)

NATIONAL CONFERENCE

OF CATHOLIC CHARITIES

OFFICE OF THE EXECUTIVE DIRECTOR

1346 Connecticut Avenue, N.W., Suite 307 • Washington, D.C. 20036 • (202) 785-2757

EPISCOPAL LIAISON
The Most Reverend
Timothy J. Harrington, D.D.

PRESIDENT
Rev. Donald F. Dunn

FIRST VICE PRESIDENT
Dr. Helen McDaniel

SECRETARY
Mr. Harold K. Coyle

TREASURER
Mr. Edward A. Gallagher

EXECUTIVE DIRECTOR
Rev. Msgr. Lawrence J. Corcoran

July 7, 1978

Honorable Paul G. Rogers, Chairman
Subcommittee on Health and the Environment
2415 Rayburn House Office Building
Washington, D. C. 20515

Dear Mr. Rogers:

Because of scheduling difficulties we were not able to present oral testimony to your Subcommittee on what we consider a very important piece of legislation -- the Adolescent Health Services, and Pregnancy Prevention Act of 1978. However, we are glad to have this opportunity to share with you our comments on this bill, based on our long history of service to unmarried mothers of whatever age. We ask that our statement be included in the hearing record.

As our enclosed statement points out: "Adolescent pregnancy, as a consequence of acting out sexuality, needs to be assessed in a social context. The origin of the problematic behavior is rooted in the families of the children, in a high proportion of cases." However, the legislation as drafted, seems to ignore, perhaps unintentionally, the importance of the role which the family of origin should rightfully have at this time of crisis. We have made several suggestions which would strengthen the role of the family and we hope the Committee will be able to accept these suggestions at its markup.

Also, we would like to call to your attention the tremendous contribution of family service agencies and maternity homes in easing the burden for unmarried parents over the years and we strongly recommend that these institutions be placed high on the list of facilities eligible for grants to carry out the purposes of the act.

Sincerely,

Mathew H. Ahmann
Associate Director for Governmental Relations

Statement of the National Conference of Catholic Charities on the Adolescent Health Services, Pregnancy Prevention Act of 1978 (S. 2910/H.R. 12146) to the Senate Committee on Human Resources and the House Subcommittee on Health (Interstate and Foreign Commerce)

The National Conference of Catholic Charities has a deep concern for the teenage mother and her child to whom services would be provided by the Adolescent Health Services, Pregnancy Prevention Act of 1978, the legislation which is before you now.

The adolescent pregnancy problem has been well documented for years, and though we are aware that the problem has become more urgent in the past decade, the history of Catholic Charities involvement with the problem goes back 250 years to a time when the Ursuline nuns came from France to New Orleans to establish a refuge for women and orphans. At that time, as today, the object of Catholic Charities was to serve the expectant mother as a whole person rather than just treat a problem pregnancy. Accordingly, she was provided with counseling, shelter, health care and training and education to make her economically independent. The same services are offered to those in need today by the Catholic Charities Movement through its 815 agencies, branch agencies and institutions. NCCC is the largest non-profit human service organization serving the American people today and in 1976 (latest figures available) provided services for 31,897 unwed mothers, 6,218 unwed fathers and maternity home care for 4,450 women.

The National Conference of Catholic Charities strongly supports the identification of "adolescent initial and repeat pregnancies" today as a major social problem in the United States. We agree that because of the serious negative consequences to the individuals, families and communities involved, the magnitude of

the problem, and the widespread geographical distribution of adolescent pregnancies there is need for the federal government to give attention to it in a specialized program, with investment of federal financial resources to enable communities in their effort to contain or eliminate the problem or to mitigate the negative consequences on the child, the adolescent parents and their families, when a pregnancy has not been or cannot be prevented.

We agree with the findings on which the legislation is based and with the intent of the legislation as stated in the bill. We do believe, however, that some modifications in the wording in several places and the addition of a relatively small number of statements in the section on purpose, services and priorities would strengthen the ability of the legislation to accomplish its purpose.

Findings and Purposes

The fundamental problem is not the fact of unwise pregnancies leading to the birth of children who have neither an adult father or mother to assume the parental role, serious as this problem is. The fundamental problem is the lack in the contemporary American culture of objective behavioral norms to guide the adolescent, and of moral standards against which the adolescent and society can evaluate the behavior, as well as the lack of environmental controls to afford protection against destructive, impulsive behavior. The problem is exacerbated by the related problem of breakdown in both family life and in parental assumption of responsibility for children's behavior. In other words, we view early and irresponsible engagement in sexual activities on the part of children, which is how many of these adolescents ought to be classified, as damaging to them physically, emotionally and spiritually whether or not such activity results in pregnancy. We view it as harmful to the boy as much as to the girl and counterproductive to the normal maturation process in adolescence. The acting out sexuality is the problem, not merely the pregnancy which is only one of the negative consequences.

Accordingly we would like to suggest the following changes in Sec. 2 (a), Findings and Purposes:

From: (1) adolescents are at a high risk of unwanted pregnancy;

To: (1) adolescents and, increasingly, children in the early years of adolescence are engaged in sexual activity that is damaging to them physically, emotionally and morally and is counterproductive to the normal maturation process in early adolescence. As one consequence, adolescents are at a high risk of pregnancy;

From: (5) the problems of adolescent pregnancy and parenthood are multiple and complex and are best approached through a variety of integrated and essential services:

To: (5) the problems of adolescent acting out sexuality, pregnancy and parenthood are multiple and complex and are frequently associated or rooted in a problematical situation in the family. They are best approached through a variety of integrated and essential services.

In (6) insert the phrase "nor their families" so that it would read:

(6) such services, including a wide array of educational and supportive services, often are not available to the adolescents who need them, nor to their families, or are available but fragmented and thus of limited effectiveness in preventing pregnancies and future welfare dependency;

Paragraphs (2) (3) (4) and (7) of this section would remain unchanged. NCCC accepts and deplores the findings in these sections — the number of pregnant adolescents (one million in 1975); the severe adverse health, social, and economic consequences for both mother and child; the evidence of repeat pregnancies and the necessity for a federal policy to develop appropriate health, educational and social services where they are lacking.

USES OF GRANT

We note that the funds provided under this Act may be used by grantees to (1) link services to prevent initial and repeat pregnancies and to assist adolescents to become independent and productive; (2) to identify and provide access to other services; (3) to supplement services not adequate in the community; (4) to plan for administration and cooperation of services; (5) to provide technical assistance and (6) training.

Adolescent pregnancy, as a consequence of acting out sexuality, needs to be assessed in a social context. The origin of the problematic behavior is rooted in the families of the children, in a high proportion of cases. Siblings of the pregnant adolescent and of the putative father are very often and predictably apt to follow the same pattern of behavior.

As drafted, the program proposed appears to address neither of these factors although we recognize this omission was not the intent of the framers of the legislation. The bill appears to subsume the inevitability of continuing, widespread sexual activity in children and seeks to control one single consequence. It fails to address any services to the parents and the families of origin of the children involved. The only reference to the family is to authorize fixing fees in relation to the ability and willingness to pay the costs of service to the adolescent.

We would suggest, then, that Sec. 102 (a)(1)(A), which now reads:

"prevent unwanted initial and repeat pregnancies among adolescents;"

be expanded to read:

"assist adolescents to develop a better understanding of the meaning of sex in human life and to change destructive acting out sexual behavior and prevent initial and repeat pregnancies."

We would also suggest adding to this section another service to become 102 (a)(1)(C):

"assist families in which there is a pregnant adolescent and/or an adolescent and siblings at high risk to resolve the problems associated with, or causative of, the behavior."

We are also concerned that the major purpose of the bill appears not to be to provide services but to support projects that will help communities coordinate existing programs. In fact, in this bill federal support of services would be limited to 50% of the grant. NCCC does not concur that the major administrative problem is failure to "coordinate." The major problem is the complete lack of services in some communities, insufficient services in other communities or inaccessibility to services in neighborhoods or areas where they are needed most. We agree that coordination of services is an important objective but such coordination can be achieved by properly following the priorities listed in Sec. 103, (a)(3) without fixing a funding limit in the legislation. Sec. 102 (e) makes the provision that no more than 50% be spent on services and we would therefore recommend this section be struck.

Priorities, Amounts and Duration of Grants

Family service agencies and maternity homes are the two institutions which have historically carried the burden of service to unmarried parents in all age groups and have consequently had their resources stretched beyond their capacity to meet the demand for services. In many communities they are the most competent and knowledgeable resource and the one with credibility to serve as the key agency in establishing the network of coordinated services proposed in the legislation. They should certainly come high on the list of facilities eligible for grants to carry out the purposes of this legislation and their services should be made available not only to the adolescent but to the families of these children as well.

We would suggest that the phrase "and their families" be added to the end of Sec. 103 (a)(3). And in Sec. 103 (a)(4), which lists the types of facilities which shall have priority for grants, we suggest the following langauge be added:

> ...maternity homes which do or can be equipped to provide comprehensive services to pregnant adolescents and agencies serving families, youth and children with established programs in this area of service.

Requirement for Grant Approval

One of the objectives of the bill as stated in the short title is "to provide care to pregnant adolescents." Since the origin of the problem is frequently in the social environment, the priorities should lead off with family and parent-child counseling in order to strengthen the families of origin and to get at the causes of the behavior and provide potential for growth and change. The family is at a point of crisis when the pregnancy is discovered and it is at this point that it is most amenable and open to professional help.

This rationale applies also to achieving another objective of the bill, "to help adolescents become productive independent contributors to family and community life." This will also require family centered social services as well as direct health and educational services to the adolescent.

We believe these objectives would be better attained with some additional language in Sec. 104 (a)(5). This section lists the core services as (A) family planning services; (B) health and mental counseling; (C) vocational counseling; (D) educational services; (E) primary and preventive health services; (F) nutritional services, information and counseling. We suggest adding a new "(B)" to read: "Family and parental counseling." The succeeding paragraphs should then be designated (C) through (G).

Although the problem is identified in the bill as a serious and widespread one, the funding is established at a figure that is little more than a token in

view of the costs of service and the numbers of families and individuals involved. For instance, in most cases, one adolescent pregnancy may involve seven people — the baby, the teenage mother, the teenage father and the four parents of the teenagers.

Because of the number of people involved and because of the kinds of services provided, we believe the proposed program would be best administered by the Office of the Assistant Secretary for Human Development in HEW rather than in an office whose primary concern is in the health field.

In conclusion we wish to commend the Administration and the Congress for giving attention to this growing national problem and for its efforts to find a solution. The National Conference of Catholic Charities supports you in these efforts and we feel that the amendments we have suggested will strengthen the legislation so that the program can better meet its objectives.

[Whereupon at 5:15 p.m. the subcommittee was adjourned.]